Organisation des soins de santé mentale pour les personnes atteintes d'une maladie mentale grave et persistante. Y a-t-il des données probantes?

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Centre fédéral d'expertise des soins de santé
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Organisation des soins de santé mentale pour les personnes atteintes d'une maladie mentale grave et persistante. Y a-t-il des données probantes?

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PREFACE

Se pourrait-il que le degré de civilisation d'un pays se mesure à la manière dont il se comporte vis-à-vis des malades psychiques et des handicapés mentaux ? Depuis l'analyse critique de Michel Foucault, au milieu du siècle passé, les soins de santé mentale ont pris un tournant radical dans la plupart des pays occidentaux. L'impulsion en ce sens n'a pas d'abord été de nature scientifique mais plutôt politico-philosophique et éthique. En même temps, de gros progrès sur le plan du traitement médicamenteux ouvraient de nouvelles possibilités. Avec comme résultat que le regard sur les maladies psychiques et sur l'institutionnalisation psychiatrique s'est profondément modifié. Il est apparu clairement qu'on ne voulait plus continuer de la même manière. Mais beaucoup moins clairement comment procéder autrement.

Sur base d'un certain nombre de grands principes, des expériences ont été tentées dans diverses directions. L'ambition de ce rapport est de faire le point sur ce que ces expériences nous ont appris à propos de nouvelles formes possibles d'organisation des soins de santé mentale. L'étude se rapproche fort de celles publiées dans le rapport KCE n°84 de 2008, relative aux séjours psychiatriques dans les lits T et dans les rapports n° 103 en 123 qui donnent une évaluation provisoire des projets thérapeutiques en santé mentale.

Que cette préface ne donne pas l'illusion que la recette idéale est connue. L'impact favorable éventuel d'un nouveau mode d'organisation peut rarement être démontré de manière fiable. Néanmoins toute une série de leçons devraient pouvoir être tirées d'exemples vécus en Belgique et à l'étranger. La traduction de celles-ci dans la réalité institutionnelle complexe de notre pays est encore une autre histoire qui devra être écrite en collaboration avec tous les acteurs concernés.

Entretemps, nous espérons que ce travail pourra amener un certain nombre d'éléments utiles à la discussion et nous remercions les experts externes et les validateurs qui ont contribué à la réalisation de cette étude.

Jean Pierre CLOSON
Directeur général adjoint

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Résumé

INTRODUCTION

Une réflexion politique sur la manière de mieux organiser les soins de santé mentale (SSM) est menée depuis les années 1990 en Belgique. Le présent rapport a pour objectif de contribuer à cette réflexion et donne un éclairage sur d'une part l'organisation générale des soins et sur certains aspects de la coordination et de l'intégration des soins d'autre part. Il se penche particulièrement sur les personnes qui présentent une affection mentale exigeant des soins chroniques et complexes

MÉTHODOLOGIE

Ce rapport est basé sur une étude de la littérature scientifique (Medline, Embase, PsycInfo, Cochrane et base de données CRD) et sur un aperçu international de l'organisation des soins aux personnes atteintes d'une maladie mentale dans 6 pays européens et en Australie. Ces pays ont été sélectionnés sur le conseil d'experts.

DÉFINITION : MALADIE MENTALE GRAVE ET PERSISTANTE

Dans les documents politiques belge, c'est la notion de « personnes ayant des besoins en soins chroniques et complexes » qui est utilisée.. Dans la littérature scientifique, le groupe cible est défini comme les « personnes souffrant d'une maladie mentale grave et persistante (MMGP) ». Cette notion n'est toutefois pas clairement définie dans la littérature. D'un point de vue théorique, la majorité des descriptions s'appuient sur 3 piliers : le diagnostic, la durée de la maladie et la gravité des limitations fonctionnelles. Toutefois, il n'existe de définition standard pour aucun de ces piliers.

Les **groupes diagnostiques** auxquels il est le plus souvent fait référence sont la schizophrénie et les troubles bipolaires, parfois aussi les dépressions ou troubles de la personnalité récurrents/majeurs.

Pour renvoyer au **caractère chronique**, on utilise généralement une durée minimale de 6 mois.

Les **limitations fonctionnelles** ne sont en règle générale pas définies de manière explicite.

Une estimation prudente évalue la prévalence annuelle des MMGP à environ 1% de la population globale.

Le groupe cible pour ce rapport a été limité aux adultes. Pour des raisons pratiques, la psychiatrie judiciaire a été exclue, de même que les problèmes d'addiction, sauf en combinaison avec une autre maladie mentale (« double diagnostic »).

RÉSULTATS DE L'ÉTUDE DE LA LITTÉRATURE

ORGANISATION GENERALE DES SOINS DE SANTE MENTALE

Ce chapitre aborde en premier lieu les concepts de désinstitutionalisation et de « balanced care »; les résultats de la littérature sont présentés ensuite.

Désinstitutionalisation

La désinstitutionalisation, appelée aussi socialisation, est un choix socio-éthique qui sous tend l'organisation actuelle des soins de santé mentale (SSM). La socialisation des SSM implique que l'on approche les personnes souffrant d'une MMGP comme des citoyens à part entière et qu'on vise leur *réintégration* dans la société. Cette tendance sociale a vu le jour dans les années 1960 et a révélé qu'un grand nombre des patients qui séjournaient auparavant dans des institutions étaient capables, moyennant l'aide nécessaire, de vivre en société, avec à la clé une amélioration considérable de leur qualité de vie. Cette tendance sociale se développait parallèlement à une forte amélioration des possibilités de traitement médicamenteux, ce qui a sans aucun doute soutenu la désinstitutionalisation. A l'heure actuelle, la désinstitutionalisation renvoie au processus qui privilégie une forme non résidentielle de soutien (donc réduction de lits), qui veille à une diversification de l'offre de soins pour couvrir le spectre plus large des besoins des patients, et qui fait en sorte que la responsabilité concernant les soins dispensés à un patient soit partagée entre plusieurs institutions et personnes.

Le modèle « balanced care »

Le modèle général dans lequel l'organisation des SSM doit être située aujourd'hui, est le modèle « balanced care ». Dans ce modèle, on tend à offrir une diversité d'équipements, afin que le traitement et les soins soient possibles à un niveau proche du domicile (de préférence), mais aussi en hôpital (si nécessaire). Le modèle adhère à une logique de dispensation de soins graduelle : il vise prioritairement le traitement et les soins de la première ligne, mais passera si nécessaire aux soins de deuxième ou troisième ligne. Cette approche concerne tant le traitement médical que les demandes de soins et d'assistance pratiques. Le modèle repose en partie sur des preuves scientifiques, mais s'est également développé de manière pragmatique sur la base d'expériences de désinstitutionalisation, et notamment sur la constatation que la suppression progressive de lits d'hôpital ne doit pas être poussée jusqu'à l'extrême.

Le modèle « balanced care » ne précise pas un nombre exact de lits d'hôpital ou de places en soins ambulants. Cette proportion dépend de la gamme de services disponibles dans un pays ou une région déterminés et des conceptions sociales et culturelles locales.

Organisation générale des soins : résultats de l'étude de la littérature

Le présent rapport se concentre sur la dispensation de soins en dehors des hôpitaux psychiatriques. Pour ces derniers, il est renvoyé au rapport KCE n°84. Le niveau de preuve des études trouvées est faible voire modéré dans le meilleur des cas. De nombreux motifs méthodologiques expliquent cette situation, dont le plus important est la complexité des interventions. De multiples éléments jouent de ce fait un rôle dans chaque intervention, rendant difficiles les comparaisons entre groupe d'intervention et de contrôle. Les constatations décrites ci-dessous se recouvrent d'ailleurs en partie.

- L'intervention de crise dans le lieu de vie des personnes souffrant d'une maladie mentale, par une **équipe « out reach » ambulante**, apparaît aussi efficace qu'une hospitalisation et est davantage appréciée. Ceci vaut également pour les soins de crise en hôpital de jour. Toutefois, pour certaines personnes, l'hospitalisation reste nécessaire.
- On ne dispose pas en suffisance de matériel d'étude sur la plus-value du **traitement** en **hôpital de jour** lorsque celui-ci ne s'inscrit pas dans une situation de crise. On ne dispose pas non plus de suffisamment de matériel d'étude sur les centres de jour pour les personnes souffrant d'une MMGP.

- **Le traitement multidisciplinaire ambulant** dans un centre de santé mentale est, pour les personnes atteintes d'une MMGP, aussi efficace qu'un traitement en hospitalisation, et mieux accepté.
- Le **traitement à domicile** des maladies mentales, avec une visite à domicile régulière et une approche médicale/sociale combinée, peut, en comparaison avec une hospitalisation initiale, réduire la durée d'éventuelles hospitalisations ultérieures, mais cet effet était plus explicite dans les études américaines que dans les études européennes.
- Le « **supported employment** » (emploi assisté) pour les personnes souffrant d'une MMGP et candidates à une revalidation par le travail, est plus efficace s'il est proposé « sur place » dans le cadre d'emplois normaux du marché du travail, plutôt que par le biais d'une formation dans un centre de revalidation.
- Concernant l'utilité d'équipes d'intervention précoces lors de psychose imminente, il y a trop peu d'études de qualité suffisante disponibles actuellement pour pouvoir se prononcer.

INTÉGRATION DES SOINS, CONTINUITÉ DES SOINS, PROGRAMMES DE SOINS ET RÉSEAUX DE SOINS

Définitions et concepts

Il existe un grand manque de précision, voire même une certaine confusion dans l'utilisation de notions telles qu'intégration des soins, continuité des soins, programmes de soins et réseaux de soins. Nous exposons ci-dessous un certain nombre de caractéristiques résumant de manière pragmatique ce qui a été trouvé à ce sujet dans la littérature.

Intégration des soins

L'intégration des soins est une notion complexe, dans le cadre de laquelle les aspects suivants sont abordés :

- le *niveau d'organisation des soins* sur lequel l'intégration s'appuie : s'agit-il d'une intégration au niveau du *patient individuel* (p. ex. ACT, voir ci-dessous) ou d'une intégration pour un *groupe de patients* et donc au niveau du système de soins (p. ex. entre deux hôpitaux ou entre médecins de famille et un service ambulant de soins de santé mentale) ;
- l'*intensité* de l'intégration des soins, allant d'un accord de coopération très libre à un degré élevé d'intégration ;
- les *accords et règles* relatifs à cette intégration des soins, allant d'accords verbaux informels présentant une grande liberté d'interprétation personnelle, à des procédures et règles formelles.

L' intégration des soins renvoie en d'autres termes à la manière selon laquelle les différentes partie du système de soins sont intégrées, que ce soit au niveau des politique nationales ou locales, au niveau des équipements (au sein de et entre plusieurs secteurs) ou encore au niveau des professionnels. Il existe certains sous-types d'intégration des soins ayant leur propre concepts, p. ex. le « shared care ». Le rapport scientifique donne plus d'informations à ce sujet.

Continuité des soins

La définition initiale (Bachrach, 1981) de la continuité des soins était la suivante : « un système de santé offre une continuité des soins lorsque le patient peut parcourir les divers éléments qui le constituent de manière ininterrompue ». Il s'agit plus précisément de :

- la continuité dans la **collaboration** entre secteurs : (1) entre plusieurs professionnels des soins de santé, (2) au travers de l'intégralité des soins offerts, (3) grâce à une proximité géographique favorisant l'accès aux soins ;
- la continuité dans le **temps** (continuité longitudinale) : (1) le maintien du contact avec le patient, (2) la continuité du professionnel des soins de santé, (3) de la prestation de services (programme de soins), (4) et la transition entre les différentes formes de soins (par exemple en cas de sortie de l'hôpital) ;
- la manière dont le patient **ressent** les soins (coulant et ininterrompus).

La « continuité des soins » est considérée dans de nombreux documents de politique comme une condition importante pour l'amélioration des soins aux personnes atteintes d'une maladie mentale.

Programmes de soins et réseaux de soins

Un programme de soins est défini dans ce rapport comme l'ensemble des activités qui sont proposées dans le cadre des soins cliniques à un groupe déterminé de personnes souffrant de maladie mentale.

Un réseau de soins est un accord de coopération entre institutions ou professionnels du même secteur ou de secteurs différents, qui collaborent en vue de réaliser un objectif commun au niveau du patient ou d'un groupe de patients. Un tel réseau se caractérise par une affiliation explicitereconnaissable et par des accords ou règles définissant la manière dont les membres du réseau accomplissent leur missions et partagent leurs responsabilités et pouvoirs de décision.

Impact de l'intégration des soins, de la continuité des soins, des programmes de soins et des réseaux de soins

Intégration et coordination des soins au niveau du patient individuel:

- L'« **assertive community treatment** » (ACT) renvoie à une équipe multidisciplinaire qui coordonne les soins dans le lieu de vie de la personne souffrant d'une MMGP. Cette équipe procède le plus possible elle-même aux interventions nécessaires, plutôt que de renvoyer le patient vers d'autres professionnels des soins de santé (et ce, contrairement à la gestion des cas (case management) décrite ci-dessous). Grâce à l'ACT, un nombre plus grand de personnes atteintes d'une MMGP semblent capables de s'installer et de travailler de manière autonome.
- L'ACT peut aussi, pour les personnes souffrant d'une MMGP, réduire le nombre d'hospitalisations ainsi que le nombre de personnes qui disparaissent de la vue des professionnels des soins de santé. Ces résultats découlent essentiellement d'études réalisées aux Etats-Unis, et n'ont pu être confirmés dans un certain nombre d'études européennes. Des études récentes indiquent que le nombre d'hospitalisations diminue surtout s'il existait précédemment une fréquence élevée d'hospitalisations.

- Le « **case management** » **(CM)** (gestion de cas) implique qu'un professionnel des soins de santé se charge de la coordination des soins pour un certain nombre de patients ; il existe plusieurs variantes dont certaines s'apparentent étroitement à l'ACT. Le CM peut faire en sorte qu'un nombre inférieur de personnes atteintes d'une MMGP disparaissent du suivi, mais l'effet sur les paramètres cliniques, sociaux et autres est moins explicite.
- En ce qui concerne les personnes faisant l'objet d'un **double diagnostic** (maladie mentale et problème d'addiction), il n'y a jusqu'à présent pas de preuve scientifique qu' une approche intégrée de deux affections produise de meilleurs résultats.

Intégration et coordination des soins au niveau des organisations de soins

Quelques études importantes, randomisées à grande échelle, démontrent que l'intégration des soins est possible au niveau des institutions de soins ou entre différents professionnels et que les efforts déployés pour une meilleure intégration des soins conduisent à des contacts de collaboration plus intenses et plus rapides. Toutefois, ces études montrent que, le plus souvent, ceci semble n'avoir qu'un impact limité sur la continuité des soins au niveau des patients, ou sur la symptomatologie clinique ou la qualité de vie de la personne atteinte d'une MMGP. Les sans abri souffrant de MMGP peuvent cependant être maintenus plus longtemps dans un logement stable.

Il existe très peu d'étude qui ont porté spécifiquement sur l'impact de la continuité des soins entre différentes institutions de soins. Les interventions qui tentent d'améliorer la continuité des soins lors de la sortie de l'hôpital en sont un exemple. Mais ici aussi, l'effet sur la symptomatologie clinique ou sociale ou sur la qualité de vie de la personne souffrant d'une MMGP n'est pas clair. Au vu des faiblesses méthodologiques des études, des recherches supplémentaires sont nécessaires.

Aucune étude n'a été trouvée concernant les programmes de soins pour les personnes souffrant d'une MMGP. Pour les réseaux de soins, quelques études étaient disponibles mais aucune conclusion claire n'a pu en être tirée.

Enfin, il convient de veiller à ce que l'attention consacrée à l'organisation des soins ne se fasse pas au détriment de l'attention consacrée à la qualité des aspects du contenu des services. Il n'existe en effet aucune preuve convaincante que l'intégration et la continuité des soins conduisent à une réduction de la symptomatologie clinique ou à une meilleure qualité de vie des personnes atteintes d'une MMGP. De plus, « ineffective services are not improved by better integration » (Goldman A 1994).

APERÇU INTERNATIONAL

Cet aperçu vise à dresser un tableau général de l'organisation des soins de santé mentale en France, aux Pays-Bas, en Espagne, au Danemark, au Royaume-Uni, en Australie et en Belgique.

Des processus de réforme des soins de santé mentale sont en cours dans tous ces pays et chacun rencontre pas mal de difficultés à ce propos.

Un problème récurrent au cours de cette enquête internationale a été le peu d'informations et de chiffres disponibles sur la manière dont certains concepts ont été mis en œuvre sur le terrain, sur le contexte dans lequel cela s'est déroulé et sur l'impact final. Il est dès lors très difficile d'interpréter les informations trouvées.

... « comme tous les autres citoyens affectés d'un problème médical ou psycho-social »...

Tous les pays sous revue ont aspiré ces dix dernières années à relier le plus possible le traitement et le soutien des personnes atteintes d'une maladie mentale au reste des soins de santé et de l'aide sociale, en sorte qu'elles soient traitées comme tous les autres citoyens.

Désinstitutionalisation et réintégration: où en est-on?

Parmi les pays étudiés, l'Australie a progressé très loin dans un modèle organisationnel basé sur le principe de la désinstitutionalisation : le nombre total de lits psychiatriques est très faible (25 lits pour adultes par 100.000 habitants en 2007, contre 127/100.000 en Belgique), dont 53% situés dans un hôpital général (contre 18% en Belgique). Les rapports d'évaluation australiens attirent toutefois encore et toujours l'attention sur le besoin urgent de logements adaptés en dehors de l'hôpital, dont le développement est encore insuffisant alors que des efforts sensibles ont été réalisés pour la fourniture de soins.

Le nombre de lits au sein des hôpitaux psychiatriques est encore élevé dans la majorité des autres pays étudiés (p. ex. la France, les Pays-Bas, voir tableau récapitulatif dans le rapport scientifique). On reconnaît que le développement de logements et de services adaptés dans les milieux naturels de vie, est insuffisant. Au Royaume-Uni, par contre, l'offre résidentielle est relativement faible, et l'accent est mis sur les soins ambulants spécialisés par le biais des CMHT (community mental health teams), en ce compris les « assertive outreach teams » qui opèrent en déplacement auprès de la population concernée si nécessaire.

Il y a en Belgique de longues listes d'attente avant de pouvoir séjourner de manière extra hospitalière dans une MSP (maison de soins psychiatriques) et une HP (initiative d'habitation protégée pour patients psychiatriques), et pourtant les normes maximales fixées par la loi ne sont pas atteintes. Des mesures telles que le soutien aux activités de la vie quotidienne ou au travail, ne sont pas abordées de façon suffisamment structurée, comme c'est d'ailleurs le cas dans la plupart des pays européens.

Dans quelques-uns des pays étudiés, l'accent est mis avec insistance sur le rôle du médecin de famille dans le diagnostic et le traitement de maladies mentales en général (pas seulement les MMGP). L'organisation globale des soins de santé de ces pays joue un rôle à cet égard. En Australie, l'introduction de tarifs spéciaux pour les médecins de famille en ce qui concerne les soins de santé mentale a connu un grand succès ; les médecins de famille sont également encouragés à suivre la formation nécessaire. En 2005, 5% du budget total réservé aux soins de santé mentale ont été attribués aux médecins de famille. Les psychiatres ont eux aussi certains avantages financiers s'ils soutiennent la collaboration avec le médecin de famille. Au Royaume-Uni, le rôle des soins de santé primaires pour les maladies mentales est fortement souligné dans les documents officiels, mais on ignore dans quelle mesure le médecin de famille assume réellement ce rôle. En Espagne, 89% de toutes les maladies mentales sont traitées au niveau primaire. Des critiques concernant la qualité sont parfois formulées dans la littérature à ce sujet, d'autant plus que cette caractéristique doit être resituée dans une offre relativement limitée de soins spécialisés (voir tableau récapitulatif 14.1.6 dans le rapport scientifique).

Soins intégrés, continuité des soins, programmes de soins et réseaux de soins

Dans chacun des pays étudiés, en ce compris la Belgique, des concepts tels que la coordination des soins, la continuité des soins et les soins intégrés sont explicitement et abondamment mis en exergue dans de nombreux documents officiels. Tous les pays étudiés, cela conduit à des expérimentations au sujet de la meilleure manière de mettre ces concepts en œuvre. Toutefois, on n'a encore dans aucun pays l'impression d'être arrivé à une solution définitive et satisfaisante. Dans la plupart des cas, les résultats concrets des mesures introduites ne sont pas étudiés de manière spécifique.

Au niveau du patient

Coordination des soins de santé mentale & coordination entre soins de santé et aide sociale

En France et en Espagne, ce rôle est depuis plusieurs décennies officiellement confié aux centres de santé mentale. Ces centres, rangés parmi les institutions de soins spécialisés, ne parviennent toutefois pas à l'assumer, pour diverses raisons, entre autres à cause en raison de listes d'attente un peu partout.

Au Royaume-Uni aussi, les centres de santé mentale (CMHT) jouent un rôle de coordination et semblent mieux y réussir. Pour le MMGP, les CMHT doivent en outre mettre sur pied des 'assertive outreach teams' qui assurent un rôle de coordination. Les anglais ont en outre recours depuis les années 1990 à la « Care Program Approach » (CPA). Cela signifie que, pour chaque personne atteinte d'une MMGP, un programme de soins est établi et régulièrement évalué ; de plus, un coordinateur de soins est désigné. On entend toutefois la critique que le système CPA serait formaliste et qu'en réalité, la collaboration entre les soins de santé et l'aide sociale, serait difficile.

En Australie, la coordination des soins sur le plan médical est confiée au médecin de famille ou au psychiatre en fonction de celui qui est considéré comme le médecin traitant principal ; pour les personnes souffrant d'une MMGP, un coordinateur de soins est financé, lequel coordonne les soins de santé et l'aide sociale. Quant à savoir si cette coordination des soins fonctionne ou pas, aucun résultat n'est connu.

Les Pays-Bas ont introduit dans les soins de santé mentale des « programmes de soins » visant la continuité des soins au niveau de l'usager de soins (programmes souvent développés au niveau local et mis en œuvre, selon les estimations, par 60% des services existants). Aucun document étudiant la qualité du contenu ou les effets de ces programmes de soins, n'a été trouvé.

En Belgique, on a tenté jusqu'à récemment, par le biais des « projets thérapeutiques », de voir comment on pourrait arriver à une meilleure coordination (et ce, pas uniquement au niveau du patient).

Au niveau des organisations de soins ou de la politique générale

Coordination des soins de santé mentale

En France, cette coordination est encouragée par le biais de la formation de réseaux entre organisations, jusqu'ici sans grand succès.

Le Royaume-Uni a créé, pour appuyer les changements, pas moins de 170 « LITs » ou « *local implementation teams* ». Ces équipes ont pour tâche spécifique de constituer, de superviser et d'accompagner des équipes locales proposant des soins dans une région déterminée. Ces LITs doivent veiller à ce que les besoins en soins soient couverts dans leur région. Bien que cela ne soit pas leur objectif premier, les LITs jouent un rôle global dans la coordination entre les soins résidentiels et ambulants. Ce modèle de LITs reçoit généralement une évaluation assez positive. A noter qu'il existe aussi des LITs pour d'autres groupes cibles que les personnes atteintes de maladie mentale.

En Australie, l'Etat établit à intervalles réguliers, et ce depuis déjà les années 1990, un 'Mental Health Care Plan', en collaboration avec tous les acteurs des soins de santé mentale. La coordination des soins au sein des soins de santé mentale y constitue une question prioritaire constante.

En Belgique, une grande partie des soins et du soutien aux personnes atteintes d'une MMGP relève de l'assurance maladie fédérale. En revanche, les soins et le soutien aux personnes nécessitant des soins de longue durée relèvent principalement de compétences communautaires et régionales, comprenant dans son offre diverses fonctions de logement, d'accueil de jour, d'ateliers protégés, d'assistance à la gestion budgétaire personnelle, d'accueil provisoire pour décharger les intervenants de proximité, etc. Dans le cas des maladies mentales (à l'exception des personnes souffrant d'autisme), cette compétence régionale se limite principalement à l'organisation de centres de santé mentale. L'offre de soins actuelle pour les personnes atteintes d'une MMGP est dès lors plus limitée et moins variée que celle pour les personnes souffrant d'un handicap mental ou autre. D'une manière générale, cette décentralisation des compétences entraîne souvent un manque de visibilité et une complexification de l'organisation des soins. Le récent programme interministériel visant une meilleure prise en charge de la santé mentale dans le cadre de ce qu'on appelle l' 'article 107' est un nouveau pas dans la direction d'une plus grande concertation et collaboration au sein des soins de santé mentale. Ce programme est en cours de concrétisation.

Le projet pilote relatif aux soins psychiatriques à domicile, qui stimulait la concertation et la transmission de l'information entre la première ligne et les 2ième – 3ième lignes, a également été mis en place de manière définitive. Il y a aussi au niveau fédéral l'organisation de 'plateformes de concertation', qui forment la base d'une concertation continue entre les différents acteurs en matière de planification des soins de santé mentale. En Région wallonne, les « *Centres de référence de santé mentale* » sont tenus d'assurer la coordination entre les différents centres de santé mentale.

Coordination entre les soins de santé et l'aide sociale

Au Royaume-Uni, les LITs jouent un rôle global dans la coordination entre « cure » et « care ». Les NHS Care Trusts ont également pour tâche spécifique de faciliter la collaboration entre NHS (health care) et les autorités locales (welfare). Les organisateurs des soins de santé et de l'aide sociale sont également tenus, au Royaume-Uni, de se concerter au niveau local. Les résultats concrets de toutes ces mesures n'ont toutefois pas été étudiés de manière spécifique.

Au Danemark, les « health agreements » entre les soins de santé et l'aide sociale (entre régions et autorités locales) sont obligatoires et sont tenus d'aborder le sujet des équipements sociaux pour personnes atteintes d'une MMGP. Le Danemark possède également des plateformes régionales, où a lieu une concertation permanente à propos de la planification des soins de santé et de l'aide sociale.

En Australie, des acteurs du domaine de l'aide sociale sont également impliqués dans l'établissement du Mental Health Care Plan. Ce Plan est régulièrement évalué en profondeur, en ce compris les différents sous-aspects des soins de santé mentale mais aussi de l'aide sociale ; les résultats sont rendus publics dans un rapport conjoint (soins de santé-aide sociale).

Aux Pays-Bas, l'organisation des soins de santé mentale était jusqu'en 2008 basée sur les *circuits de soins intégrés* : tant le traitement (« care ») que l'aide et l'assistance pratique (« cure ») étaient abordés. L'ensemble était financé par une seule instance publique (l'AWBZ), ce qui jouait, selon des documents officiels, un rôle important dans la réussite du système. Le système a été entièrement réformé en 2008 dans le cadre des réformes générales conduites aux Pays-Bas, mais aussi parce que les SSM se compartimentaient trop (« kokerzorg ») et n'étaient pas assez en harmonie avec les soins de santé et l'aide sociale en général. Les options auraient, au sein de ce « kokerzorg », été trop limitées pour les usagers de soins. Pour finir, les grandes institutions de soins acquéraient trop de pouvoir et leur politique n'était pas assez transparente.

En Belgique, figure dans les objectifs du programme interministériel relatif à une meilleure prise en charge des soins de santé mentale dans le cadre de l'article 107, que la collaboration entre les soins de santé mentale et l'aide sociale doit aussi être optimalisée.

RECOMMANDATIONS

- **Il convient de poursuivre la désinstitutionalisation des personnes souffrant d'une maladie mentale grave et persistante, en s'appuyant sur le modèle « balanced care » et sur l'organisation actuelle des soins en Belgique ;**
- **Ceci n'est réalisable que moyennant le développement progressif de formes de soins et d'accueil dans l'environnement personnel du patient, rendant possible un degré maximal d'intégration dans la société, et en se basant sur les besoins individuels de chaque patient ;**
- **Les autorités doivent veiller à la poursuite d'une diversification de l'offre d'habitations protégées en variant les formules en termes d'autonomie et d'intensité dans le soutien ;**
- **De plus, les soins et l'assistance non résidentiels aux personnes MMGP doivent être développés méthodiquement en accordant une attention spéciale à l'accompagnement des activités quotidiennes et au soutien à la reprise d'activités professionnelles ;**
- **Un accompagnement multidisciplinaire intensif des personnes souffrant d'une MMGP et qui sont fréquemment ré hospitalisées, doit être encouragé, par ex. sur la base du modèle ACT ;**
- **L'aspect financier ne peut freiner aucun patient à évoluer vers la forme de soins la plus appropriée ;**
- **Le développement de formes de soins et d'accueil doit se baser sur les structures de soins existantes et doit de préférence avoir lieu d'une manière systématique, et échelonnée. Sur la base des connaissances scientifiques actuelles et des chiffres disponibles, il n'est en effet pas possible de prévoir avec exactitude quelles formes de soins et combien de places seront nécessaires ;**
- **Des évaluations critiques intermédiaires sont nécessaires, aussi bien au niveau du processus de soins qu'au niveau du patient. L'Australie peut à ce sujet, être prise comme modèle ;**
- **Il est absolument nécessaire de toujours décrire explicitement dans les documents de politique ou les discussions sur l'organisation des soins ce que l'on entend par circuits de soins, réseaux de soins, coordination des soins, soins intégrés ou continuité des soins, afin d'éviter qu'un même terme soit utilisé pour des notions organisationnelles très différentes.**
- **Le développement des soins proposé requiert la coordination nécessaire entre le niveau politique fédéral et régional.**

Agenda de recherche

- **Grâce aux RPM (résumés psychiatriques minimaux), la Belgique dispose d'une base de données très détaillée, par référence aux normes internationales, des hospitalisations psychiatriques, en ce compris un certain nombre de données fonctionnelles sur les patients concernés. Une analyse scientifique approfondie et une exploitation systématiques de ces données sont souhaitables et peuvent générer des informations importantes pour les autorités ;**
- **Il conviendrait d'envisager une manière de suivre le trajet de patients atteints de MMGP lorsqu'ils quittent l'hôpital. Ceci pourrait se faire par une combinaison, voire une extension d'enregistrements existants.**

Scientific summary

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1 INTRODUCTION AND RESEARCH QUESTIONS

In 1999, the Minister of Public Health Care, decided to fund new initiatives in Mental Health Care. As an answer to the international tendency towards de-institutionalisation of psychiatric care, these new initiatives should deal with collaboration between different care providers in mental health care. The Belgian Government also approved the WHO Resolution of 2002, based on the World Health Report 2001, in which it is advised to adjust the global health care organisation of the country to the specific situation of mental health care.

The National Advisory Council for Hospital Services further elaborated these decisions, and on July 10th 2002, they formulated an advice with the following key-concepts: 1. all mental health care should be centralized around and tailored to the needs of each individual patient. 2. quality of care implies continuity of care, in an environment that is as natural as possible to the patient. 3. to realize these aims, mental health care providers should collaborate starting from the competences of each of them. It was proposed to explore this renewed vision on mental health care by initiating "projects", which would be evaluated and eventually re-oriented before they would be implemented nationally. In 2004, the responsible Ministers decided to give priority to the group of "chronic, complex and long-lasting" mental disorders; and a royal decree on October 22 2006 stipulated the conditions for the creation and development of the projects.

The National Institute for Health and Disability (NIHDI) and the Federal Public Services (FPS) for Public Health were mandated to elaborate the projects. (also called "Therapeutic Projects"). Their evaluation is dealt with separately (1st document: KCE-report n° 103)

At the same time, it was felt that it would be appropriate to evaluate the current scientific knowledge and literature evidence on organisational aspects in mental health care, and to evaluate the evolutions in psychiatric care in other Western countries. These topics are the main objectives of this KCE-report.

The research questions of this report are formulated as follows:

First question

How can chronic complex psychiatric patients be defined? Which diagnostic groups or subcategories are generally distinguished under this umbrella term? Which scientific criteria can be used to identify the group?

Second question

Which evidence and knowledge is available on the outcomes of organisational health services aiming at rehabilitation and integration of the target groups? How do these organisational models fit into the concept of "programmes of care"? Is there any evidence on the effectiveness of these programmes of care for the defined target groups?

Third question

What are good practices examples of the integrated rehabilitative health care approaches in other countries? Which financing models for the care of the target groups of chronic complex patients are used in the "good practice" countries?

Fourth question

What recommendations can be formulated on the organisation and financing of health care for chronic complex psychiatric patients? How can the available knowledge be translated to the Belgian health care policy and health services field of mental health care?

Following the research questions, the basic methodologies used in this report will be:

1. a literature search based on the principles of EBM, reviewing scientific evidence on mental health care organisation in general as well as continuity of care, care programs and integrated care more specifically;

2. a description of relevant topics of mental health care organisation in other Western countries, based on available literature including information from grey sources e.g. websites, as well as on consultation of foreign experts.

For practical reasons, this report contains two parts: 1. literature review. 2. international comparison.

2 GENERAL BACKGROUND: DEFINITIONS AND SCOPE OF THE STUDY

The main focus of this study is on how mental health care should be organised for the group of "chronic and complex" mental disorders, and more specifically what the role can be for "continuity of care", "programmes of care" or an integrated health care approach.

The next paragraphs will specify the definitions and the limitations used in this study.

First, a definition will be given for "mental disorder" and for "a chronic and complex mental disorder".

Next, it was felt that it was necessary to look for a valid construct to order the various types of mental health care organisation. Using a comprehensive classification system of mental health services (a "mental health services typology") will ensure that it is complete and relevant.

Third, the general perspective for outcome evaluation is defined; and it is explained what are relevant outcome domains to take into consideration.

2.1 CHRONIC AND COMPLEX MENTAL DISORDERS: DEFINITIONS AND SCOPE OF THE STUDY

2.1.1 Definition: Mental disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is the handbook used most often in diagnosing mental disorders. According to the authors of the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, fourth Edition, Text Revision)[1], a "mental disorder" can be defined as follows: "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural or biological dysfunction in the individual. Neither deviant behaviour (e.g. political, religious or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above".

The fifth chapter of the ICD-10[a], containing the WHO's International Classification of Mental and Behavioural Disorders, defines mental disorders as: 'the existence of a clinically recognizable set of symptoms or behaviour, associated in most cases with distress and with interference with personal functions". In the introduction of the previous version, the ICD-9, it is mentioned that for the description of some contents, there was a collaboration with the authors of the DSM.

In the introduction of the ICD-10, the issue of terminology is brought along. It is proposed to use "mental disorder" rather than "mental illness" or "mental disease", because the first expression has a more neutral connotation than the other ones.

In this study, the term "mental disorder" will preferably be used.

Many caregivers conceptualize mental disorders based on other models. However, it was beyond the purpose of this study to conduct an exhaustive review on existing definitions of "mental disorders".

a http://www.who.int/classifications/apps/icd/icd10online/

2.1.2 Definition: "Chronic" or "severe and persistent" mental disorders

Chronic diseases theoretically are diseases which have one or more of the following characteristics: they are permanent, leave residual disability, are caused by non-reversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care. (Dictionary of Health Services Management, 2d ed)

For chronic and/or complex or severe mental disorders so far no generally accepted definition exists. Currently, most authors prefer the expression "severe and persistent" to the word "chronic", which is felt to have a negative connotation. According to the scientific literature (see overview KCE-report n°84), the definition of "severe and persistent" psychiatric patients most commonly includes 3 components (DDD): "diagnosis", "disability" or severity of illness (or degree of functional impairment) along the spectrum of a certain diagnosis, and "duration" of illness. Recently, the importance of "disability" over "diagnosis" is stressed by some authors (e.g. Ruggeri 2000)[2]. In 1997, Slade[3] proposed five components (SIDDD), by adding "safety" and "formal/informal support".

Nevertheless, these considerations are still largely theoretical. In the large majority of the published scientific papers discussed in the literature review of this report, inclusion criteria for the group of severe and persistent mentally disordered patients are limited to the medical diagnosis and eventually the duration of the disorder (see further). This limits so far the available scientific evidence as to the disability-concept. In the grey literature, the concept of "disability" is used more often.

As to the "duration" of the disorder, a previous report (KCE-report n° 84) mentions limits in the literature between 6 months and 2, 3 or even 5 years as cut-off in the definition of "severe and persistent psychiatric patient". A difficulty remains that in some publications duration of illness is taken into account, and in other duration since the first contact with professional help.

2.1.3 Additional limitations of the scope of this study

The main focus of this study was put on adults (18-65 years). Mental health care for elderly and children implies specific aspects related to age, and often their needs are taken care of in separate organisational units.

In this report, substance abuse and addiction will only be dealt with when combined with another psychiatric diagnosis (the so-called "dual diagnosis" patients). This is in line with the practical application of the term "severe mental illness" throughout most of the scientific literature (see Part 1 Literature review). Forensic psychiatry is not included because of the overlap with service provision in the domain of jurisdiction and criminology.

In this report, especially in the literature review, a minimum of six months' duration of illness was considered to be an indication of "chronic" or "severe and persistent" pathology, in case of doubt whether a certain publication could be considered to deal with "chronic" or "severe and persistent" psychiatric patients or not. This is in line with the lower limit for duration as defined in the KCE-report n°84.

Further limits are defined in 2.2.4.

2.2 ORGANISATIONAL FORMS OF PSYCHIATRIC CARE: DEFINITIONS AND SCOPE OF THE STUDY

2.2.1 Introduction

In the following paragraph, a definition is given for the concept of "mental health services".

Next, a (comprehensive) classification system of mental health services (a "mental health services typology") is searched for. This classification system will be used as a general frame work, to avoid omissions in the literature search and to have some common (though certainly imperfect) and preferably quantifiable basis to start from in the international comparison.

2.2.2 Definition: Mental health service

Clear definitions of "Mental Health Service" are rare. Only in some of the documents retrieved to find a "mental health service typology" (see further), a clear definition of this concept is given. The WHO defines mental health services (MHS) as "the means by which effective interventions for mental health are delivered"[b]. In the paper on the development of the WHO-ICMHC (2000) by de Jong[4] a definition is given for "psychiatric care" and for "psychiatric rehabilitation". Johnson S, Kuhlmann R and the EPCAT group[5, 6] defined MHS as follows (2000):

"All facilities which have as a specific aim some aspect of the management of mental illness and of the clinical and social difficulties related to it. Facilities provided by health service, social services, voluntary sector and private sectors are to be included. Generic services which are important for many mentally ill people, but not planned with their specific needs in mind (e.g. generic facilities for the homeless, offices dealing with welfare benefits) are excluded. Primary care facilities not specializing in mental health care are excluded, as are services whose sole purpose is provision of counselling or psychotherapy, except where they explicitly identify as major target groups individuals with severe mental illnesses such as schizophrenia or those who are in contact with secondary mental health services."

In this study, the word "service" will be used for "facility", and not for "content of interventions".

2.2.3 Typology of mental health services

2.2.3.1 Typology of mental health services: search strategy

Medline was searched (June 2007) using the Mesh-terms "mental health services" and "classification" and the free term "development". In a second search, the limit "review" was added to the same two Mesh-terms. Of the 79 publications retrieved in the first search and the 102 publications retrieved in the second search, 5 respectively 4 were considered to be related to the subject of the study, based on Title and Abstract. Further reading of the full articles revealed that only two articles actually described a comprehensive classification system for mental health services in developed countries: the ESMS (European Service Mapping Schedule, 2000)[5] and the WHO-ICMHC (International Classification of Mental Health Care, 2000) (see further)[4] . A third reference[7] described the European Socio-Demographic Schedule or "ESDS", an instrument identifying a set of socio-demographic characteristics which, on the basis of currently available evidence, are associated with an increase of psychiatric morbidity; but this is beyond the scope of this report. References of the described publications were searched for additional information and one more publication was retained[6].

b http://www.who.int/mental_health/resources/en/Organization.pdf

Because some tools used in organisation and management of health services are not published in databases like Medline, other sources (grey literature) were looked for. Websites from organisations known for their involvement in public health and health organisation worldwide, e.g. WHO, were searched for "Mental Health Services" (Full list of websites: see appendix). Books on this topic were consulted[8, 9]. Finally, the search terms "Mental Health Services AND International Comparison" were used in Google, whereby after the first five pages no more relevant information was found. Overall, a total of 5 references to mental health services classification systems were found in the grey literature.

2.2.3.2 *Typology of mental health services: results*

Types of classification systems for mental health care

Johnson described[6] in 1998 in her survey on European mental health services classifications, 4 main subgroups:

- classification systems meant to be an inventory or taxonomy of mental health services;
- classifications based on style and theoretical basis of mental health programs;
- classifications based on description of the precise content of interventions delivered within a programme or facility;
- methods of studying which focus particularly on the links ("networks") which individual services of mental health care have with one another.

In the same paper it has been recognised that prior to comparing the precise content of different services, a decision needs to be taken whether the services are similar enough in their purposes to be comparable, and hence a taxonomy of mental health services is necessary. The same is true for the description of "networks" between different services.

Since the purpose of this study is to provide information to the government, rather than to health care providers, it seems not appropriate to look for classification systems based on the background of the provided therapy, but rather to look for general inventories or taxonomies of mental health services. Even so, although it proved to be difficult to gather information on existing mental health facilities in the studied countries (see further), it would have been even more difficult to gather information on the precise content of interventions delivered within a programme or facility.

Inventory classification systems for mental health services

The search strategy describe previously (paragraph 2.2.3.1) yielded 9 inventory systems for mental health services.

In the overview of Johnson[6] et al in 1998, taxonomies available at that time are described. Only two provide an inventory of all services types, including hospital as well as community services. The first, proposed by the **CSAGC** in the UK (1995), does not provide precise definitions of the terms used in the classification. The second on the other hand, proposed by the **WHO in 1987**, consists rather of a description of existing types of facilities in different countries, without really providing a consistent framework.

The **WHO-AIMS version 2.2 (2005)** is designed for low- and middle-income countries[c], so its use in Belgium might not be relevant.

Another **WHO-instrument[d], described in 2003**, makes a general subdivision in mental health services in primary health care, community-based mental health services, and mental hospital institutional services; each category has two subdivisions. However, it is clearly stated in the text that it is only "an attempt to describe various types of services" and has not been validated.

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c http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf

d http://www.who.int/mental_health/resources/en/Organization.pdf

In a **2005 policy paper of the European Observatory on Health Systems and Policies**[e], the following subdivision is used:

- primary care
- mainstream mental health care
  - outpatient/ambulatory clinics
  - community mental health teams
  - acute inpatient care
  - long-term community-based residential care
  - work and occupational services
- specialized mental health services (e.g. highly specialized services for people with eating disorders or a dual diagnosis, assertive community treatment (ACT), sheltered or independent living arrangements).

Whereas the first level should be available in all countries, the second level should be available in middle-income countries and the third level in high-income countries like Belgium. The purpose of this classification is not to be comprehensive, but rather to map broadly the variety of services in different countries.

The "**Basic service profile**" was developed by Thornicroft and Tansella[9] and is more comprehensive, but not validated. The main categories are: out-patient and community services, acute in-patient services, longer-term residential services, and services providing an interface with other services (e.g. social services or welfare benefits).

Other classification systems described in the book of Thornicroft and Tansella [9]are the two classification systems also found in Medline (the WHO-ICMHC and the ESMS), as well as the "**Spectrum of Care**", developed by the Department of Health in Britain (1996). The "Spectrum of Care" has 3 main categories[9]: home-based services, daycare & out-patient ambulatory services, residential services hospital/non-hospital. Each of these 3 categories is subdivided in 2 other categories: acute/emergency and long-term/continuing care. The core components of each level are described[f]. The system is developed to be used in the British National Health Service (NHS).

The **WHO-ICMHC (International Classification of Mental Health Care, 2000)**[4] does not belong to the category of taxonomies for mental health services, but rather to the category of classifications based on description of the content of interventions delivered within a programme or facility (see higher). It contains 10 modalities , e.g. psychological interventions, psychopharmalogical and other somatic interventions, taking over daily living activities, care coordination etc. (for details see Appendix). A definition for each of the modalities is given. The use of the scale takes place in three steps: identifying the module of care to be classified - classifying the module(s) of care according to qualitative aspects i.e. the 10 modalities - rating the extent of provision of each modality in each module (4-level scale). Data on psychometric properties (inter-rater reliability) are available. The WHO-ICMHC and the ESMS are considered as complementary.

The **ESMS (European Service Mapping Schedule, 2000)**[5] provides a service mapping tree (see Appendix) with a total of 4 basic categories and 33 subtypes of services. Each category and subdivision is well described in a glossary. The second section of the schedule provides a protocol for making quantitative assessments of service use per 100 000 population for each of the service types. The system was tested for inter-rater reliability; and tested for use in several European countries. The 4 basic categories are:

- Residential (secure, acute or non-acute); including time limited and indefinite stay;
- day & structured activity (acute or non-acute); including work, work-related activity, other structured activity and social support;

[e] http://www.euro.who.int/observatory/Publications/20050126_1

[f] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005877

- outpatient & community (emergency or continuing care)
- self-help and non-professional help.

2.2.3.3 Typology of mental health services: conclusion

Only one taxonomy for classification of mental health services in highly developed countries has been tested and validated for use in several countries: the ESMS. This system will be used as a general frame work in this study, to avoid omissions in the literature search and to have some common (though certainly imperfect) quantifiable basis to start from in the international comparison of organisational types of psychiatric care.

2.2.4 Additional limitations of the scope of this study

Given this typology, some more limits are added to paragraph 2.1.3. Because the KCE-report n°84 has dealt with organisational aspects of inpatient mental health care, the literature review of the current report especially focuses on aspects related to semi-residential care, outpatient and community care, and day activities or work-related issues. Self-help and non-professional activities are excluded as well.

2.3 OUTCOME EVALUATION: GENERAL PERSPECTIVE

In this report, several outcome domains were taken into consideration, and classified along five main categories (see also Appendix to chapter 3, evidence tables):

- service utilisation
- clinical outcome (measuring general or disease specific physical health status including general psychological well-being and cognition (IQ))
- disability and handicap (role functioning focussing on ability to perform activities of daily life)
- social outcome (social functioning)
- quality of life or patient/carer satisfaction with care (generic or disease specific)

This classification respects the WHO International Classification of Functioning, Disability and Health (ICF), which is the translation of the world-wide accepted WHO bio-psycho-social model[g] into the field of rehabilitation and chronic care.

The same subdivisions have been recognised in 2 systematic reviews on outcome measurement in psychiatry, one by CRD (Centre for Reviews and Dissemination, 2003)[10] and one by Slade (2002)[11]

The classification into several domains as proposed for this study, has also been applied in many handbooks on rating scales and questionnaires to measure health (e.g. "Measuring Health" by Ian McDowell, 2006; "Measuring Health" by Ann Bowling, 2005)[12, 13]. Note that "general psychological well-being" usually is considered as a separate category, but that the overlap with disease specific scales for mental disorders has been mentioned ("Measuring Health" by Ian McDowell, 2006, p 208); in this report these two categories are taken together.

[g] http://www.who.int/classifications/icf/site/beginners/bg.pdf

2.4 EVIDENCE-BASED HEALTH SERVICES RESEARCH AND HEALTH CARE POLICY

The main target of this report concerns organisational aspects of mental health care, especially mental health care for persons with severe and persistent mental disorders. The purpose is to gather "evidence" around this subject.

It deserves to be discussed as to what type of evidence is aimed at.

2.4.1.1 Evidence based Medicine

In the 1970s and 1980s, the concept of "evidence-based medicine (EBM)" was gradually spread worldwide. Its purpose was to improve the quality of medical decision-making by allowing practitioners to use more easily the ever increasing amount of available scientific information. At the same time, it was an attempt to de-emphasize the need to rely on intuition, authority and subjectivity (Zarkovich 2002)[14].

In 1996, Sackett defined EBM as: "…the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Dobrow 2004)[15]. After many waves of adaptation, the full concept is now described as "patient-centred care based on the best available evidence", including the following three points: first, the entire decision process should be subjected to full scientific scrutiny whatever the nature of the evidence or individual clinical experience; second, interventions should be justified on economic as well as on clinical grounds (cost-effectiveness); third: interventions should incorporate the values and preferences of both the individual patient and the wider society (preference-driven medicine) (Greenhalgh 1997, Rycroft-Malone 2004)[16, 17]. Indeed, it is recognised that context–specific factors can and should play an important role in medical decision-making.

Whereas the primary source of justification for clinical decision-making is based on quantitative or deductive reasoning (like in experimental trials), context-specific factors often can better be evaluated by qualitative research using inductive methods (such as surveys or focus groups) (Greenhalgh 1997). Both types of evidence should be rigorously evaluated using their own scientific methods, to judge their quality and scientific merits.

Many authors nowadays admit that quantitative and qualitative evidence can be seen as complementary and should be integrated (Knapp 2007, Dobrow2004, Rose 2006, Rycroft-Malone 2004)[15, 17-19]. This also implies that the choice for one or another type of research should be adapted according to the type of research question for which an answer is sought. One possible classification of questions and corresponding research types is given by Jenkins et al (in: Knapp et al. 2007) (see fig): e.g. when the research question concerns effectiveness and cost-effectiveness, the preferential research type is the RCT. On the other hand, to evaluate intervention acceptability ("will there be a demand for this intervention?") or satisfaction, qualitative research is more apt.

2.4.1.2 Evidence based Health services research

The main focus of this report is on "mental health care organisation". The relationship between "health care organisation" and "health care outcome" is a complex one, and the research involved in this kind of questions belongs to the domain of "health services research (HSR)". Indeed, a better understanding of the influence of organisational forms and organisational regimes on outcome is one of the future challenges for the evidence research agenda (Anthony 2003; Priebe 2002)[8, 20].

Literature reviews in HSR, as it is recognized in many papers, are characterized by heterogeneity of the evidence, and quantitative as well as qualitative research should be included (Greenhalgh 2005)[21]. Moreover, it is recognized that formal protocol-driven search strategies may fail to identify important evidence, and that informal approaches including browsing and "asking around" can substantially increase the yield of search efforts (Greenhalgh 2005). The KCE HSR methodological procedure note (ref website) indeed recognize that HSR requires a multitude of research types.

It advises to make use of several databases and several types of information including grey literature and expert consultation when conducting HSR, all depending on the research question; however all sources used should be well-documented.

Golder et al (2008)[22] recognize the difficulty in developing a valuable search strategy in this type of literature review, because there is often a wide range of potentially useful databases and a lack of standardized terminology. Searching a large number of databases with broad search strategies might identify most of the relevant publications, but might also yield a large numbers of irrelevant records.

The CRD (Centre for Reviews and Dissemination) guidance for undertaking reviews in health care (2009)[h] treats qualitative and quantitative evidence as *complementary*; with the qualitative evidence offering an explanation for, and interpretation of, the quantitative findings. Qualitative findings can help explain, interpret and implement findings from effectiveness reviews. According to CRD, the main reason why this so-called "mixed-method" is used increasingly in primary health care research, is to enhance relevance in the decision-making process, by shaping questions of importance to end users, understanding heterogeneous results, identifying factors that impact on the implementation of an intervention etc.

In concluding on evidence about health services there is a need to integrate several types of evidence, e.g. social science evidence and clinical outcome research. As also pointed out by CRD, this integration also requires new models of research synthesis; several techniques to combine quantitative and qualitative data exist (e.g. realist synthesis, critical interpretive synthesis) (Mays 2005; Dixon-Woods 2005)[23, 24]. A common practice is that researchers include qualitative data embedded in quantitative research, but it has been advocated that ideally a separate quantitative and qualitative review are undertaken ("parallel synthesis") which are then brought together.

Hence, a more or less 'classical' search of the peer-reviewed literature, as was undertaken in this report, can be considered to be only one part of what ideally should have been the scope of the literature review . Insofar as interventions in the realm of (mental) health care organisation can also be considered as a "social construction", in which contextual factors tend to take an overriding influence, the discussion rapidly becomes a sociological one, bringing up fundamental societal choices. This KCE report does not have the ambition of addressing the latter comprehensively, and did not perform a separate search to find qualitative research, although qualitative research papers and/or comments found occasionally were also included. On the other hand, it is not sure that an extra search for qualitative literature would have yielded much additional information to support decision-making in mental health care organisation; a first impression is that it would not.

Besides a literature review, an cross-country international comparison also often belongs to the field of HSR, and is also part of this report. Whereas data collection relies on the same principles as the literature review, data from grey literature and informal contacts usually become much more important due to the scarcity of peer-reviewed publications. For potentially relevant topics to include, the KCE process notes refer to the WHO 2007 publication[i] that provides a template for health systems analysis.

h http://www.york.ac.uk/inst/crd/report4.htm

i http://www.euro.who.int/Document/E88699.pdf

2.4.1.3 *Evidence based Policy*

Across all sectors of public policy, there is an increasing recognition of the need to take account of evidence in the decision-making process. This is named "evidence-based policy (EBP)", or sometimes "evidence-informed policy" (Knapp 2007)[18]. When moving from EBM to EBP, the decision-making context shifts from the individual-clinical level to the population-policy level. Since consequences of decisions directly affect larger numbers of people, a clear knowledge of the "mean" effectiveness of a certain intervention as measured by RCTs becomes even more important (Upshur 2001)[25]. Yet, if studies are only selected, based on the RCT-research design principles, there will be a tendency towards interventions with a medical rather than a social or organisational focus. Similar arguments have been developed in the debate on issues related to health inequality policies (Asthana 2006)[26]. Selecting information of RCT as a source of evidence will strengthen the role of pharmacotherapy, compared to social and psychological interventions (Slade 2001, Tanenbaum 2003)[27, 28].

On the other hand, contextual issues to take into account in EBP are much broader and include a demographic, political, economical, social, institutional context etc. (Knapp 2007)[18]. Knowledge of the specific local situation, e.g. cultural patterns or accessibility of specific services is mandatory. Policy making typically considers the view of many different stakeholders. Consequently, it is important in EBP to consider various views and "multiple perspectives" on the same sort of evidence, such as the perspective of service users, of professionals, of informal carers, of the policy makers themselves (Rose 2006)[19]. As a further consequence, normative and ethical debates are as important as clinical cost-effectiveness issues: e.g. the deinstitutionalisation movement has the characteristics of a social movement. It was a normative, ethical and destigmatisation choice to integrate people with mental disorders into society. Integration of all these types of evidence and all the different perspectives is necessary to respond to the needs of policy makers.

2.4.1.4 *Evidence: scope in this report*

This report deals with evidence on organisational aspects of mental health care.

Goldman et al (2000)[29] describe two different types of evidence that apply to the field of organisational aspects in mental health care. The first type is *"clinical services research"*. In this type, it is difficult to distinguish completely the treatment intervention from the organisational strategy, and the treatment is embedded in and/or identified with a particular organisational strategy (e.g. case management, assertive community treatment, residential treatment). The unit of analysis is the individual. The second type is *"service systems research"*. Service systems strategies work at the organisational level, often employing financial incentives or regulatory efforts, attempting to alter programs and policies to support improved care for groups of patients (e.g. what are appropriate roles for primary care providers and for specialty care providers respectively?). Whereas both types of research can inform on the contribution of the organisation of services on health, the second type is less available in mental health care organisation than the "clinical services research".

There is no denial that classical EBM-type research has to play an important role in informing on how mental health services should best be organised. But a broad analytical perspective is needed. In order to understand the applicability of certain models, it is essential to take into account the complexity of factors affecting the organisation models.

A specific difficulty arising in many publications is the lack of precise information on the provided services, or the use of a similar term for services that may or may not provide the same the same things (e.g. Burns 2001, Catty 2002)[30, 31]; a phenomenon sometimes called the "black box" intervention. This lack of precise information on the services model can have major implications for interpreting "evidence" related to outcomes.

In this report, the basic databases searched were the Cochrane databases of systematic reviews, CRD database, Medline, Embase, and PsycInfo. As to the type of studies, (systematic) reviews and meta-analyses (if available), randomized controlled trials, controlled clinical trials, cohort studies and case-control studies were retained. References of the retrieved references were scrutinized, and experts were consulted to inform on important publications that were missed.

Consequently, limitations to this search strategy are the fact that sociological databases (e.g. Social Sciences Citation Index (SSCI)) were not included, which might yield another type of publications e.g. a higher number of studies based on qualitative research. On the other hand, a first impression is that an extra search in these databases would not have yielded much additional publications appropriate for this study. Also, no attempt was undertaken to include other sources of information than peer-reviewed publications, e.g. grey literature.

When reading this report, these limitations should be kept in mind. Besides, in another KCE-report we will evaluate a Belgian programme which attempted to stimulate a wealth of therapeutic approaches centred around organisational innovations.

Table: Matrix of evidence and corresponding research type (source: Knapp et al: Mental health policy and practice across Europe (2007)[18])

Table 5.1 A matrix of evidence

Research question	*Qualitative research*	*Survey*	*Case-control studies*	*Cohort studies*	*RCTs*	*Quasi-experimental studies*	*Non-experimental evaluation*	*Systematic review*
Effectiveness: does this work better than doing that?				+	++	+		+++
Process of service delivery: how does it work?	++	+					+	+++
Salience: does it matter?	++	++						+++
Safety: do benefits outweight risk of harm?	+		+	+	++	+	+	+++
Acceptability: will there be a demand for this service?	++	+			+	+	+	+++
Cost effectiveness: is this a good use of scarce resources?					++			+++
Appropriateness: is this an appropriate intervention to deliver?	++	++						++
Satisfaction with service: are users, providers and other stakeholders satisfied with the service?	++	++	+	+				+

Key: +++ Most robust evidence ++ Reasonable evidence + Can provide some weak evidence

Source: Adapted from Petticrew and Roberts (2003). This matrix was itself adapted from an original by Muir-Gray (1996).

3 LITERATURE REVIEW: METHODOLOGY

3.1 INTRODUCTION

3.1.1 European Service Mapping Schedule (ESMS)

In order to make sure that the literature search would be comprehensive, it was performed starting from a basic typology for which the ESMS (European Service Mapping Schedule) had been chosen, an instrument for the description and classification of mental health services (Johnson et al 2000)[5] (see chapter 2). The Service Tree of the ESMS is shown in the Appendix. Each ESMS subdivision is defined in the ESMS-Manual.

3.1.2 Types of study to be included

As to the study type, meta-analyses, (systematic) reviews, randomized controlled trials, controlled clinical trials, cohort studies and case-control studies were included, since it was estimated that focussing on (systematic) reviews and RCTs only might be too restrictive for the subject under evaluation (organization of mental health care).

Apart from classical EBM[i] type publications, and although not specifically looked for, qualitative research was also taken into account when it resulted from the performed search strategy. Also, when qualitative studies were reported in other types of publications (e.g. in an RCT or an observational study), it was taken into account.

3.2 SEARCH STRATEGY, IN- AND EXCLUSIONCRITERIA

The following databases were searched:

- -Cochrane Database of Systematic Reviews; CRD Database (CRD-reports, DARE, HTA)
- -Medline (Ovid); PsycInfo; Embase

3.2.1 Cochrane Database of Systematic Reviews and CRD Database (CRD-reports, DARE, HTA)

For the search in the Cochrane Database of Systematic Reviews (July 2007) and the CRD Database (CRD-reports, DARE, HTA) (July 2007), the following terms were crossed:

- -mental* ill* or mental* disorder* or psychiatr*
- -severe* or persistent* or chronic*

Applying the main in- and exclusion criteria (see further), 26 results were obtained in the Cochrane database and the CRD-database.

To make sure no important systematic reviews would be missed, a second round-up of the Cochrane library was performed in Nov 2009.

i EBM: evidence based medicine, see chapter 2

3.2.2 Medline (Ovid), PsycInfo, Embase.

3.2.2.1 Reference retrieval

For each ESMS subdivision, a separate search question was introduced by looking for appropriate thesaurus terms and supplementary free terms. Examples of search strategies are presented in the Appendix to chapter 3; the full search strategies can be obtained from the authors on request.

Most search questions were limited to the years 1997-2007, because most of the important, already retrieved literature reviews or meta-analyses (Cochrane or CRD database) went back to 1997 (or 1998) for their literature review. If a high quality literature review or meta-analysis of a later date was available, only studies from that date on were included. When still too many search results for one search question were obtained, the search was further limited to studies concerning adults (18-65 years).

Finally, the reference list of all included studies was looked through for additional publications relevant to the research question.

To make sure no important references had been missed, a second, independent researcher developed another search strategy (Medline), which was compared with the search strategy of the first researcher (see Appendix to chapter 3).

Because of the importance of "care pathways" and "care networks" for this report, an additional search has been performed on these topics (Nov 2009).

3.2.2.2 Reference evaluation

In- and exclusion criteria

For the theoretical background, see chapter 2.

Further specification of inclusion criteria:

Some indication that it concerned "chronic" or "severe and persistent" mental disorders had to be present.

Only studies in peer-reviewed journals were taken into consideration.

In publications type EBM (Evidence Based Medicine), outcome had to be evaluated by quantifiable variables like days of hospitalisation etc., or by means of at least one validated, peer-reviewed outcome instrument (rating scale or questionnaire) on one of the 5 domains specified above (see chapter 2). It should also be noted that many scales or questionnaires contain items of several domains and not just of one single domain.

Further specification of exclusion criteria:

Studies concerning outcome effects/assessment of care for the chronically mentally ill, not including studies concerning medication trials or studies concerning content of specific forms of individual therapy (delivered from face to face).

Studies focussing on family interventions or patient/family education were not included, since this was considered to be a certain form of therapy.

Studies on alcohol or substance abuse were excluded, unless patients with dual diagnoses were considered (mental health disorder and alcohol/substance abuse) (see also 2.1.3).

Studies on aspects of forensic psychiatry and issues involving jurisdiction were excluded because of the overlap with service provision in the domain of justice (see also 2.1.3).

Studies on adults with intellectual disabilities and psychiatric disorders, as well as on post-partum mother-and-child services were excluded, because it was felt that a more specific search strategy might be necessary to retrieve all relevant publications. Studies on prevention, including prevention of suicide, were excluded.

All studies describing longitudinal assessment of SMI persons discharged because of asylum closure were excluded, since this topic has been dealt with in KCE report n°84, and by now the scientific literature considers these results to be well-established.

Studies dealing with issues on inpatient care are not included since they are subject of the KCE report 84 (see also 2.2.4).

Studies on self-help and non-professional services are excluded as well.

Studies conducted in developing countries were excluded.

Studies on cost or focussing on economic aspects were not included.

Further details: see Appendix to chapter 3.

Critical appraisal of the literature

First, articles retrieved through the Medline, PsycInfo or Embase search were sifted on content of title and abstract, according to the defined in- and exclusion criteria. The studies retained for full evaluation were then summarized using a template or reference evaluation sheet template (see Appendix to chapter 3). The quality was assessed according to the Dutch Cochrane checklists (see website Cebam: www.cebam.be). The results of the qualitative research was evaluated according to the quality of the reporting of the research strategy, results, context and eventually interpretation.

Next, the level of clinical evidence was assessed according to the system proposed by Guyatt et al.(2006)[32]. Evaluation of the level of evidence was not applied to individual studies, but to the body of evidence relating to a specific research question or literature topic.

The level of evidence according to Gyatt can be:

- High: further research is very unlikely to change our confidence in the estimate of effect
- Moderate: further research is likely to have an important impact on our confidence in the estimate of the effect
- Low/very low: further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate; or any estimate of effect is very uncertain.

3.2.2.3 Flow chart of reference selection for Medline, PsycInfo, and Embase

Flow chart for Medline(Ovid), PsycInfo, and Embase (1997-2007)(excluding Cochrane/CRD):

- The search strategies used yielded a total of 4837 references. Of these, 647 were retained based on Title/abstract and after discarding doubles.
- When comparing with the Medline search strategy of the independent second researcher, no references to be included had been missed.
- Finally, after full-text evaluation and after hand-searching reference lists of the included publications, 58 references were retained for inclusion in the review (see Summary tables in Appendix to chapter 3).
- The additional search strategies for “care pathways” and “care networks” (Nov 2009) yielded only one extra study for inclusion in the review.

4 LITERATURE REVIEW: RESULTS

In this chapter, the first paragraph will define some important concepts. For these definitions, no separate literature review has been undertaken. They are derived from the publications retrieved in the general literature review (see chapter 3) or from references of these publications. This does mean that other authors might use or prefer other definitions for the same concepts. However, throughout this report the definitions below are used in a consistent way.

From the second paragraph onwards, the results of the literature search are presented, and the organizational diversity of the mental health services retrieved from the literature is stratified according to the ESMS classification. The ESMS subcategory under concern, is named in the title of the paragraph, and is for each paragraph illustrated by the figure below the title. Next, the (systematic) reviews retrieved by the search mentioned under 3.2.1 (Cochrane, CRD) on this subcategory are mentioned, followed by additional studies retrieved by the systematic search in Medline, PsycInfo and Embase (see 3.2.2).

After the different subcategories of the ESMS have been discussed, a paragraph is added on "Continuity of care, services & systems integration" (paragraph 4.5). This paragraph is added because it spans the different ESMS categories, and because it is a special matter of interest for this study (see chapter 1 "Research questions".)

Finally, a general discussion is presented.

4.1 DEFINITIONS

4.1.1.1 Case management

In the MeSH-tree of PubMed (Medline), case management is defined as follows: "A traditional term for all the activities which a physician or other health care professional normally performs to insure the coordination of the medical services required by a patient. It also, when used in connection with managed care, covers all the activities of evaluating the patient, planning treatment, referral, and follow-up so that care is continuous and comprehensive and payment for the care is obtained".

In the 1960s, societal changes led to the political choice to care for the severely mentally ill in the community. Large psychiatric hospitals were closed down and people were treated in outpatient clinics, day centres or community mental health centres. Sharply rising readmission rates soon indicated that this type of community care was less effective than anticipated. Community services were losing contact with patients and failing to meet their complex needs. Case management is a means of co-ordinating the care of severely mentally ill people in the community, arising in the late 1970s as a response to the problems described above (Marshall, Cochrane review Case Management, 1998).

Case management is often confused with Assertive Community Treatment (ACT), an approach which evolved at the same time (see definition of ACT)

In its simplest form (referred to as 'brokerage') case management is a means of co-ordinating services. Each mentally ill person is assigned a 'case manager' who is expected to:

(i) assess that person's needs; (ii) develop a care plan; (iii) arrange for suitable care to be provided; (iv) monitor the quality of the care provided; and, (v) maintain contact with the person.

'Brokerage' case managers often lack clinical qualifications and tend to work outside established psychiatric services. The basic 'brokerage model' has evolved into more sophisticated, but poorly defined, models. Clinical Case Management emphasises the professional status and therapeutic skills of the case manager and tends to have a 'psychodynamic' basis; particular importance is placed on the healing power of the therapeutic relationship between the case manager and 'client'.

Intensive Case Management emphasises the importance of small caseloads and high intensity input, but is otherwise not clearly defined. Strengths Case Management emphasises are working with the client's skills rather than deficits. Mostly case management is practiced at varying levels of intensity and combining elements of the brokerage, clinical case management, and strengths models.

Rather than describing discrete models, Thornicroft proposed 12 dimensions that could be used to distinguish case management programs (Ziguras 2000)[33].

In practice, especially the terms Intensive case management (ICM) and ACT at times appear to be used loosely and interchangeably, the term ICM being more used in the UK and ACT more in the USA (Smith 2007, Fiander 2003)[34, 35]

4.1.1.2 Assertive Community Treatment (ACT)

According to Marshall (Cochrane review, 1998)[36], Assertive Community Treatment (ACT) is an approach which evolved at the same time as case management. Case management and ACT share the same goals, to: (i) keep people in contact with services; (ii) reduce the frequency and duration of hospital admissions (and hence costs); and (iii) improve outcome, especially social functioning and quality of life. Despite a superficial similarity, important distinctions can be made between case management and ACT. Under case management great emphasis is placed on individual responsibility of case managers for 'clients'. ACT, by contrast, emphasises team working. ACT teams attempt to provide necessary interventions themselves (rather than referring clients to other providers or agencies); preferably in 'clients' own homes or places of work. ACT teams always work with low staff to client ratios (usually 10-15 patients per member) and invariably practice 'assertive outreach', meaning that they continue to contact and offer services to reluctant or uncooperative 'clients'. ACT teams also place particular emphasis on medication compliance and 24 hour emergency cover. ACT should be practised according to a defined and validated model, based on a consensus (1995) of an international panel of ACT experts (for more details, see Thornicroft 1999)[37].

4.1.1.3 Assertive outreach teams

In England, "Assertive outreach teams" (AOT) aim to provide care to SMI persons whose needs are difficult to meet by the community mental health teams (CMHTs, see further). Priebe et al. (2003)[38] evaluated 24 AOT in London and concluded that they appeared to work much in an ACT-like way although there was a wide variation in their practices. In the UK study by Ford et al (2001)[39], the term "assertive outreach" is more close to the concept of case management.

4.1.1.4 Community Mental Health Teams (CMHTs)

Community Mental health Teams (CMHTs) also evolved in the sixties (MacMillan 1963)[40] A description of its actual content long time remained rather general: assessment and care less focused on hospital/institutional settings, offering a range of interventions tailored to the patient's specific needs and usually provided by a multidisciplinary team (Malone 2007)[40]. Nowadays, the activities of the community mental health team often become supplemented by a range of specialised teams, such as assertive community treatment or assertive outreach, early intervention services for psychosis and crisis resolution teams (Cochrane, Malone 2007)[40]. A definition for the "original" generic CMHT has been provided by Thornicroft: "A multidisciplinary team of mental health staff which has a lead responsibility for the provision of specialist assessment, treatment and care to a defined population, often defined by geographical catchment area or primary care registration. Such a team will usually provide the full range of functions necessary at the specialist care level, including initial assessment of adult patients referred from other agencies and teams, consultation to primary care staff on the management of patients, the initial provision of treatment during the onset of a disorder or the early stages of a relapse, and the continuing care of patients with longer term disabilities." Distinctions include: crisis intervention is usually a 24 hr service, assertive community treatment works on the basis of restricted case loads and early intervention restricts its focus to patients in the early stages of their illness, usually a psychotic one.

Thornicroft was also the first to describe 7 subtypes of CMHTs existing at that time (1999) in the UK, based on their association (or not) with an ACT team, crisis/acute home treatment interventions, and/or specialist teams for particular subgroups of patients[37]. This makes clear that in practice, there is an astonishing variety in how CMHTs are implemented, at least in the UK.

4.1.1.5 Shared care; shared patient-doctor decision making

In the Cochrane review on shared care in chronic disease management (2007)[41], Smith et al. refer to Hickman et al (1994)[42] for the definition of shared care. In this publication, shared care has been defined as the joint participation of primary care physicians and specialist care physicians in the planned delivery of care for patients with a chronic condition, based on an enhanced information exchange over and above routine discharge and referral (Hickman 1994). It has been used in the management of many chronic conditions, particularly diabetes. Theoretically, shared care presents an opportunity to provide patients with the benefits of specialist intervention combined with continuity of care and management of co-morbidity from generalists who maintain a responsibility for all aspects of the patient's healthcare beyond the specified chronic disease.

Shared care systems frequently include pre-specified clinical protocols, referral guidelines, continuing education of participating clinicians, specifically designed information exchange systems and ongoing audit and evaluation of services delivered. It should provide an opportunity for structured, ongoing clinical management of the specified chronic disease from both sets of providers.

A taxonomy of shared care for chronic disease was created following a survey of shared health care in the UK (Hickman 1994)[42]. This suggested that shared care systems may be defined in the following ways:

1. Community clinics: specialists attend or run a clinic in a primary- care setting with primary-care personnel. Communication is informal and depends on the specialists and primary-care team members meeting on site

2. Basic model: a specific, regular communication system is set up between specialty and primary care. This may be enhanced by an administrator who organizes appointments and follows up and recalls defaulters from care

3. Liaison: a liaison meeting attended by specialists and the primary- care team where the ongoing management of patients within the service is discussed and planned

4. Shared care record card: a more formal arrangement for information sharing where an agreed data set is entered onto a record card which is usually carried by the patient

5. Computer-assisted shared care and electronic mail: a data set is agreed upon and collected in both the specialty and primary-care setting and is circulated between the two sectors using computer systems such as a central repository or email. This system may also include centrally coordinated computerised registration and recall of patients.

6. Other: the authors of the Cochrane review on shared care (Smith 2007)[41] notice that, since the development of this taxonomy, most "shared care" interventions became more complex and multifaceted, so that they would have to be classified in the category "other".

As will be noticed, some authors prefer the term "collaborative care" instead of "shared care" when discussing liaison services (e.g. Craven 2006 and Mitchell 2002)[43, 44].

Another aspect of care provision that has been described is *shared or joined patient-doctor decision making.* This aspect does not correspond to the definition of "Shared care" as defined above. To make it more complicated, some authors also refer to this as "collaborative care" (Bauer 2006)[45, 46]; others call it "shared decision making" or "integrated care" (Malm 2003)[47]. In this report it will be called "shared patient-doctor decision making".

4.1.1.6 Integrated care

Existing definitions

The term "services integration" has been used broadly to refer to a range of service delivery initiatives aimed at improving outcomes for people with complex needs. An important assumption underlying this concept is that categorically structured (non-integrated) human service delivery systems are less able to address the needs of people with complicated problems. The goals of integration are to provide comprehensive services; to improve access to these services; to improve continuity of care; and to reduce service duplication, inefficiency and costs.(Randolph 1997)[48]. Ultimately, better service integration should lead to an improved clinical status and better quality of life for the person with mental illness (Durbin 2006)[49].

The concept of services integration is not easy; and it contains several aspects that are to be elucidated and included when defining this concept[48, 49].

A. First, services integration can be defined in terms of the *service system level* toward which activities are directed. This can be the "direct service delivery" level (for individual clients e.g. integration by case management), or the "service systems" level (for a defined population as a whole, e.g. program integration, integration at the state-level etc.).

B. Second, services integration can be viewed as a continuum, that varies in terms of *intensity* (ranging from loosely organised alliances to highly integrated organizations) and in terms of formality of *governance* (from informal, verbal agreements to formal procedures and rules).

C. Third, keeping the 2 previous levels in mind, five levels of *integration* have been proposed:

1. information sharing and communication;
2. cooperation and coordination: more organized efforts to work together e.g. joint planning, joint applications, verbal agreements for client referral;
3. collaboration: written agreements or formal procedures defining how different agencies work together to achieve a shared goal;
4. consolidation: different agencies are reorganized under one organization but continue to operate independently; the organizational structure facilitates sharing of information, coordination or collaboration while maintaining agency autonomy;
5. integration: one organization, a single authority and pooled funding, including a comprehensive range of services that can be accessed by a single application/assessment and that provides individualized client services.

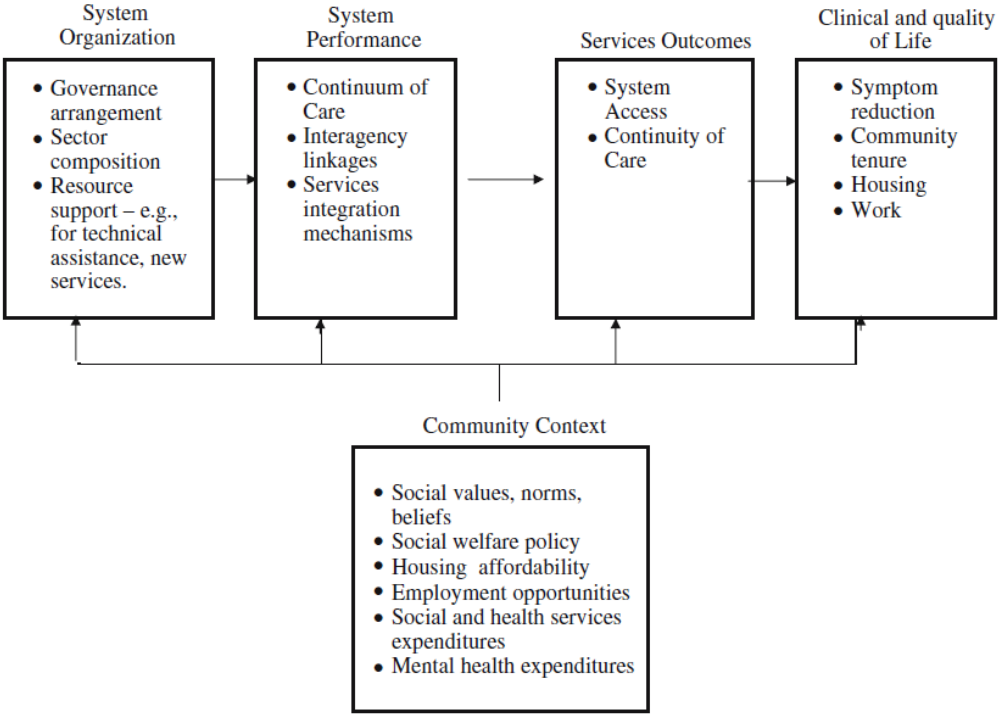
The Systems integration logic model

How service delivery initiatives aiming at integration theoretically can lead to better patient outcomes, and which intermediates presumably are to be taken into account, has been clarified in the "Systems integration logic model" (Durbin 2006)[49], shown in Figure. E.g. Improved continuity of care is presumed to be a vehicle through which systems integration improvement affects patient outcomes.

In Fig, in the first box the system components are described: governance (how are responsibilities defined? who makes final decisions?), sector composition (which types of services are provided?) and available resources. The second box presumes investigation of the way the system functions: are different service types provided so that comprehensiveness can be assured? how (intensively) are the different services and agencies linked? which mechanisms (e.g. centralized admission procedure, …) are put in place to guarantee service integration? The third box assumes that the effects of service integration are mediated by 2 intermediates, which should be measured as well: continuity of care and system accessibility.

In the fourth box, the final result of the service integration program should be measured at the patient level and along multiple dimensions (clinical symptoms, functioning in society, quality of life…). According to Durbin et al, these four steps are all influenced by the context of the community and this context also influences the final patient outcomes. E.g. in a community context of a high level of unemployment, less results can be expected from efforts to integrate vocational rehabilitation into the general service supply for SMI.

Fig: the Systems integration logic model (Durbin 2006)[49].



Durbin et al (2006)[49] mention a series of indicators that might be used to evaluate the degree of systems integration. Examples are: centralized telephone number, single set of admission procedures, inter-agency treatment teams, shared treatment protocols, etc. Inter-organizational network ratings are another way to characterize level of systems integration.

The relationship between "integrated care" and "care networks" will be explained further (see 4.1.1.7)

4.1.1.7 Continuity of care

Existing definitions

So far, no uniformly accepted definition of "Continuity of care" (CC) exists is in the literature on mental health care. We therefore mention the different aspects of this concept that we encountered in the literature review we conducted.

When discussing the definition of "Continuity of care" in mental health services, reviews usually go back to the definition of Bachrach[50] in 1981. Bachrach defined CC as "the orderly uninterrupted movement of clients among the diverse elements of the service delivery system", and he recognized 7 dimensions: longitudinal nature- individually tailored- comprehensiveness- flexibility- relationship- accessibility- communication (Bachrach 1981, Joyce 2004)[50, 51]. In the next developmental phase of the CC concept, it becomes almost impossible to distinguish it from interventions such as case management or ACT, since these interventions were basically developed to improve the continuity of care (Adair 2003)[52].

A next important landmark is the "state of the science" given by Johnson et al. (1997)[53], on "continuity of care" for severely mentally ill persons. Johnson distinguishes the following aspects of CC for SMI persons:

1. Cross-sectional:
   - receipt of a comprehensive range of services in accordance with needs:
     - continuity between service providers (degree of communication between agencies and professionals involved in the patient's care),
     - comprehensiveness (the range of services provided to meet the patient's needs),
     - accessibility of services (distance to facilities).
2. Longitudinal:
   - sustained contact with services and providers over time:
     - continuity of contact (provision of out-reaching care to stay in contact with patients),
     - continuity of service provider (patients receive services across time from the same staff),
     - implementation of service plans,
     - continuity through discharges and transfers (flexible and rapid transfer between care levels according to varying needs of patients).

In 2000, Freeman et al (Crawford 2004)[54, 55] mention the importance to add patients' views of the care they receive.

In 2004, Crawford et al combine the view of Johnson[53] and Freeman[54, 55], and base their review of CC for mental health care on the following 5 aspects:

- A: longitudinal continuity:
  - (1) patient remains in contact with services;
  - (2) no breaks in service delivery;
  - (3) patient sees the same member of staff;
- B: cross-sectional continuity:
  - (4) different components of health and social care are coordinated;
- C: experiences users and carers:
  - (5) service users experience care as smooth and uninterrupted.

Joyce et al (2004)[51] recognize 6 domains in the concept of CC, based on a thorough qualitative evaluation of the literature on CC for SMI persons and on additional interviews of SMI persons. These 6 domains largely correspond to the different aspects mentioned by Bachrach and by Johnson et al (see above); it are:

- linkages between services,
- comprehensiveness of services,
- accessibility,
- patient-provider relationship,
- degree of individualized care,
- flexibility of service location.

Whereas the previous authors focussed especially on CC in mental health care, Haggerty et al[56] in 2003 evaluate the concept of CC as it is used across the full range of different healthcare disciplines (primary and specialty health care, nursing,...). They notice that in many health care disciplines, patients are increasingly seen by an array of providers in a wide variety of organisations, raising concerns about fragmentation of care. Policy reports and charters worldwide urge a concerted effort to enhance continuity, but efforts to describe the problem or formulate solutions are complicated by the lack of consensus on the definition of continuity.

Therefore, the authors conducted a systematic literature review on the concept of continuity in health care; 19% of the references referred to CC in mental health care. They distinguished 3 types of continuity across all different disciplines of health care:

- informational continuity: the use of information on past events and personal circumstances to make current care appropriate;
- management continuity: a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs;
- relational continuity: an ongoing therapeutic relationship between a patient and one or more providers.

Haggerty adds that mental healthcare literature especially stresses the importance of a stable patient-professional relationship over time, and that this relationship is typically established with a team rather than a single professional.

Related aspects

Crawford et al (2004)[54] and Adair et al (2003)[52] recognize that CC might be *influenced* by factors at the individual (patient-related) level, program level or system level.

To *evaluate CC, several scales* have been developed, and their application field and validity has been commented on in Reid et al (2002)[k]. The Alberta continuity of services scale for mental health (ACSS-MH) is worth to be mentioned. The ACSS-MH has been developed in 2004 starting from the conceptual analysis presented by Joyce et al[51] (see above); this scale incorporates the patient's perspective as well as an independent (observer-rated) component; the psychometric properties of this scale have been documented clearly.

According to many authors (Adair 2005)[57], outcome scales to measure *whether CC is associated with a better outcome* should be multidimensional. Indeed, most authors acknowledge that CC is a complex, multidimensional process that occurs at the interfaces of multiple services in the trajectory of a patient's care and according to his changing needs.

Often, continuity of care is *linked to integrated care*; see also the Service integration logic model in Fig (see above) defined by Durbin et al[49]. According to Goldman et al. 1994[58] two fundamental principles are necessary to realize continuity of care are: integration of hospital and community services; and sectorization (responsibility of service delivery for a described catchment area).

4.1.1.8 Care Networks

A network of services can be defined as a collection of services which may vary in their activities or organization, but which share a common mission, operate in a more or less planned and collaborative manner, and participate in an overall coordinating or planning body or authority to which each has a degree of accountability (Kates N et al, 1993)[59]. In a theoretical background to networks, Goodwin (2004)[60] includes the concepts "pattern of ties or links" and "accountability"; Perry (2006)[61] defines networks on 2 continuums (social regulation and social integration); each network can be characterized by a certain degree of social regulation (hierarchy, accountability) and a certain degree of social integration (strength of binds between individuals belonging to the network)(Van den Holen 2008)[61].

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k Defusing the confusion: concepts and measurements of continuity of healthcare. Reid R, Haggerty J, McKendry R (2002). Prepared for the Canadian Health Services Research Foundation, the Canadian Institute for Health Information, and the Advisory Committee on Health Services of the Federal/Provincial/Territorial Deputy Ministers of Health. http://www.chsrf.ca/home_e.php

According to ANAES (2004)[l], care networks aim to improve access to care, to improve care coordination, and to facilitate inter-disciplinary care for a subgroup of patients, disorders or services; care networks should provide individually tailored care including diagnosis and treatment as well as prevention and patient education. Besides quality improvement, cost-effectiveness has also been mentioned as a potential advantage of care networks (Van de Holen 2008)[61].

In practice, the term "care network" is often used interchangeably with "integrated care" (see 4.1.1.5). However, the concept "integrated care" is much broader. Goodwin (2008)[62] comments on this relationship, and recognizes "care networks" as one means or form of infrastructure to promote integrated care.

4.1.1.9 Care pathways

"Care programs" and "Care pathways" in mental health care clearly belong to the focus of the main questions for this report formulated by the Belgian Government. A specific search (summer 2007; repeated in June Nov 2009 because of the importance for the report) followed by selection through the main in- and exclusion criteria, yielded no results for "Care programs", and only one review for "Care pathways" (Evans-Lacko 2008)[63].

Evans-Lacko et al (2008)[63] defined a Care pathway (or clinical pathway) as a concept that applies to "a proposed sequence of steps for clinical care for a particular group of patients". Given the specific context of mental health care, where the clinical course of the disorder can vary considerably, this could be put also as: "a whole of activities in the provision of clinical care for a particular group of persons with a mental disorder".

4.2 MENTAL HEALTH SERVICES, RESIDENTIAL, NON-HOSPITAL

4.2.1 Mental Health Services, Residential, Acute, Non-hospital.

European Service Mapping Schedule (ESMS): (see ESMS tree)
Mental Health Services – Residential – Acute - Non-hospital.

<table>
<tr><td colspan="4">SECURE</td></tr>
<tr><td rowspan="5">RESIDENTIAL</td><td rowspan="2">Generic acute</td><td colspan="2">Hospital</td></tr>
<tr><td colspan="2">Non-hospital</td></tr>
<tr><td rowspan="3">Non-acute</td><td rowspan="2">Hospital</td><td>Time limited</td></tr>
<tr><td>Indefinite stay</td></tr>
<tr><td rowspan="2">Non-hospital</td><td>Time limited</td></tr>
<tr><td>Indefinite stay</td></tr>
<tr><td rowspan="3">DAY & STRUCTURED ACTIVITY</td><td colspan="3">Acute</td></tr>
<tr><td rowspan="2">Non-acute</td><td colspan="2">High intensity</td></tr>
<tr><td colspan="2">Low intensity</td></tr>
<tr><td rowspan="4">OUT-PATIENT & COMMUNITY</td><td rowspan="2">Emergency care</td><td colspan="2">Mobile</td></tr>
<tr><td colspan="2">Non-mobile</td></tr>
<tr><td rowspan="2">Continuing care</td><td colspan="2">Mobile</td></tr>
<tr><td colspan="2">Non-mobile</td></tr>
<tr><td colspan="4">SELF-CARE & NON-PROFESSIONAL</td></tr>
</table>

l www.anaes.fr

A. Cochrane and CRD database

No references retrieved

B. Medline, PsycInfo, Embase

In 1998, Fenton et al[64] published the results of a RCT including 115 SMI persons in crisis. They were randomised to the acute psychiatric ward of a general hospital, or to crisis treatment in a eight-bed community residency with 24h supervision but continuation of their usual community rehabilitation or activities (work…). Staff of the community residency was not medically trained (as opposed to staff in a day-hospital) but were supervised by the residency psychiatrist; whereas medication prescription continued by the patient's usual outpatient psychiatrist. The results of these two treatment sites were not significantly different for outcomes at discharge and after 6 months in the domains of symptom improvement, psychosocial functioning, acute care service utilization, patient treatment satisfaction and patient satisfaction with life. Length of stay was significantly longer in the eight-bed community residency (average number of days 18.7 versus 11.7). Additional research is necessary to confirm these results.

4.2.2 Mental Health Services, Residential, Non-acute, Non-hospital, Indefinite stay (Daily support, 24h-support, Lower than daily support).

European Service Mapping Schedule (ESMS): (see ESMS tree)
Mental Health Services, Residential, Non-acute, Non-hospital, Indefinite stay (Daily support, 24h-support, or lower than daily support).

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

A. Cochrane and CRD database

Cochrane Review (2006) by Chilvers et al. "Supported housing for people with severe mental illness"[65].

Supported housing schemes (SHS) provide self-contained accommodation on one site, for people with SMI. Professional staff is on-site and available during office hours at least for either individual or group social support. Social support may involve counselling, information, practical help etc. In outreach support schemes (OSS) people with SMI also live in self-contained accommodation but they do not share a site with other people with SMI; however they receive regular home visits by professional outreach workers for individual social support. The aim of the review was to compare SHS with OSS or 'standard care' for people with severe mental disorder/s living in the community. No RCTs were identified.

Cochrane Review (2009) by McPherson et al. "Twenty-four hour care for schizophrenia"[66].

Twenty-four hour residential rehabilitation (a 'ward-in-a-house') is one model of care for SMI persons that has evolved in association with psychiatric hospital closure programs. Only one trial (UK, 1987) of 22 people and lasting two years was identified.

In this trial, persons with SMI lived in a house staffed by professionals who provided 24 hour care; the residents did some domestic work and self-care tasks. Outcomes were favorable as compared to other forms of community care. It is clear that this single, small trial does not allow firm conclusions. The authors conclude that currently, the value of this way of supporting people - which could be considerable - is unclear.

B. Medline, PsycInfo, Embase

A wealth of publications exists on the deinstitutionalization movement in psychiatry, including many aspects belonging to the ESMS-domain of "Residential, Non-acute, Non-hospital, Indefinite stay". As indicated in the methodological part of this report, studies describing longitudinal assessment of SMI persons discharged because of asylum closure were not part of this study and were not specifically looked for, since this topic has been dealt with in the KCE report n° 84, where an evaluation of "Organizational models as a substitution for long term care in psychiatric hospitals" can be found. Nevertheless, the publications emerging from the search strategy applied in this report are mentioned here.

Ogilvie et al (1997)[67] conducted a non-systematic review on supported housing for persons with SMI. Several qualitative studies were included, with interesting conclusions. It is clear from many studies evaluating consumers' preferences that they prefer to live in their own home and want to live alone. Quality of life of SMI persons is influenced by multiple factors, one of which is housing type or program. However, social stigma remains an important factor for people with psychiatric disabilities, affecting community reintegration; problems to find affordable housing and financial matters are also serious barriers. Last but not least, there is not a single model for developing and delivering housing to SMI persons, but the relationship between housing and service supports seems to be essential. Adequate resources for ensuring services should be in place, and an appropriate process for coordinating housing and support services.

Fakhoury et al (2002)[68] give an overview of the literature on supported housing. An extensive search yielded 28 evaluative peer-reviewed studies only, mostly consisting of cross-sectional surveys, uncontrolled follow-up studies and non-randomized controlled trials, or direct observation methods; this makes comparative evaluation of effectiveness difficult. More-over, small study samples and samples confined to small geographic areas or recruited from a single social agency, limit the generalizability of the results. An example of this can also be found in the study of Cohen et al 1999[69] (not included in Fakhoury et al). A narrative overview is given by Fakhoury et al.

A considerable diversity of models of supported housing is found, and different descriptive terms are used which overlap considerably. There is a continuum representing different levels of support, as well as different levels of group or independently living. Two tendencies exist: a more transitional, rehabilitation oriented approach in which SMI persons move as their abilities to live independent evolve, and a more maintenance oriented approach where they stay "for life".

Patient characteristics are likely to predict whether patients live in supported housing or independently: persons in the former group are more likely to be older, less educated, and unemployed; they tend to have had longer duration of hospital care and to have lower daily living skills. Their level of social skills and contacts with family and friends is likely to be poorer than for independently living SMI persons. Finally, some characteristics make SMI persons less likely to be accepted in supported housing or make it impossible for them to live independent: unpredictable aggression, extreme anti-social behaviour or co-morbid addiction problems.

The overall impression from the studies is that supported housing schemes can have beneficial effects with moderate to high satisfaction levels reported by most clients. Several studies underline the importance attached to independent living. However, problems of isolation and loneliness are reported by some residents.

The authors conclude that future research might try to identify specific features that discriminate between different settings and contribute to outcomes.

Two systematic reviews focus on the subgroup of *homeless* persons with SMI (Nelson G et al 2007; Hwang S et al 2005)[70, 71]. Both studies make the same conclusions; Nelson et al also conducted a meta-analysis. They compared the effect on housing stability of treatment by permanent housing and support, to the effect on housing stability by Assertive community treatment (ACT, see further) or Intensive case management (ICM, see further).

Nelson G et al 2007[70].

Based on 13 experimental and 3 quasi-experimental trials from the USA, the authors demonstrate significant reductions in homelessness, hospitalization and imprisonment for homeless people with SMI, resulting from programs that provided *permanent housing and support*. This implies permanent housing and single room occupancy although often some form of group living is included; staff is external to the housing rather than onsite; and the independent living and support process is controlled by the tenant.

When compared to ACT or ICM, effect size for housing stability was medium for programs combining housing and support (10 studies, 0.67), medium for ACT alone (4 studies, 0.47) and small for ICM alone (4 studies, 0.28). No significant differences were found between independent and group housing. Short residential treatment compared to standard treatment (2 studies) revealed no effect on housing outcome.

The permanent housing and support programs had no consistent effect on clinical symptoms, social functioning or quality of life compared to standard treatment. On the contrary, some ACT and ICM studies showed positive effects on psychiatric symptoms.

The effect of ACT on housing stability has also been demonstrated by the ACCESS study (see further), which was not included in the Nelson review. Further, it can be concluded from the ACCESS study that integrated care leads to better housing outcomes as compared to non-integrated care.

McHugo et al (2004)[72] conducted a RCT to evaluate the effect of providing housing and mental health services in an integrated way to SMI persons at risk for homelessness. Integrated housing services provided mental health services and housing services by a single agency, including intensive case management (ICM) and a housing services team. Parallel housing services provided mental health services by an ACT team, and housing services by community based landlords. At 18 months follow-up, both groups had spent significantly more days in stable housing. Participants in the integrated housing services (IHS) program spent less time homeless ($p<0,001$) than participants in the parallel housing services and experienced less severe psychiatric symptoms ($p<0,005$).

The IHS group and the females of the PHS reported greater overall life satisfaction and satisfaction with housing ($p<0,001$). Participants in the integrated housing services (IHS) program experienced less severe psychiatric symptoms ($p<0,005$) (Colorado symptom index). These results confirm the ACCESS study.

Key points

- **Evidence on supported living outside the old large-scale institutions mostly consists of uncontrolled follow-up studies, direct observational studies or other study designs that are prone to methodological flaws.**
- **The overall impression is nonetheless that supported housing schemes can have beneficial effects with moderate to high satisfaction levels reported by most users (see also KCE-report n°84)**
- **A considerable diversity of models of supported housing is found, and there is no "one best way". Rather there is a continuum representing different levels of support, as well as different levels of group or independent living.**
- **Well-coordinated housing and supporting services are essential, and enough resources need to be available to provide services. Further research might try to identify specific features that contribute to outcomes.**
- **Qualitative evidence emphasizes that persons with psychiatric disabilities prefer to live in their own home and want to live alone. Housing type is one factor that influences their quality of life. However, issues of social stigma, fear of loneliness and affordability appear to be barriers.**
- **Some characteristics make SMI persons less apt for supported or independent living, e.g. unpredictable aggression, extreme anti-social behaviour or co-morbid addiction problems.**
- **For homeless SMI persons, providing permanent housing and support can significantly reduce homelessness, hospitalizations and imprisonment (moderate level of evidence). It does not influence clinical symptoms, social outcome or quality of life as compared to standard treatment.**
- **Providing "housing and support services" in an integrated way to homeless SMI persons is more effective as compared to non-integrated service provision. This has also been demonstrated by the ACCESS program (see further).**
- **Results of "housing and support programs" are comparable to the effect of ACT on housing stability; for this group of SMI persons ACT has additional advantages on clinical symptoms.**

4.2.3 Mental Health Services, Residential, Non-acute, Non-hospital, Time limited stay.

European Service Mapping Schedule (ESMS) (see ESMS tree):

Mental Health Services – Residential - Non-acute - Non-hospital - Time limited stay.

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

A. Cochrane and CRD database

CRD-review by Drake et al (2008)[34]: A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders.

The focus of this review is the integrated treatment for dually diagnosed patients with severe mental illnesses and co-occurring substance abuse. Search strategy is not described, however 8 reviewers evaluated the completeness of the review. Part of the review deals with residential treatment interventions, a narrative synthesis of 12 quasi-experimental studies is presented; only one of these had been included in the Cochrane review by Cleary[73] et al (2007)(see further). Nearly all compared a more integrated with a less integrated approach, and many studies focussed on homeless dual diagnosis clients who had not responded to outpatient interventions. Some residential programs were short term (less than 6 months), other were long term (1 year or more), and 1 study compared short-term and long-term integrated residential treatment. The study heterogeneity makes firm conclusions impossible, and results were inconsistent in the different outcome domains. However, findings on substance abuse were positive for (subgroups within) the longer term programs. Findings were also positive for the longer term programs for some medical outcomes and some outcomes on community functioning, although a diversity of outcome measures was used. The authors concluded that the integration of substance abuse and mental health treatments seemed to improve a variety of outcomes, especially longer term residential treatment; but further research is required since the included studies had several types of methodological flaws.

B. Medline, PsycInfo, Embase

No additional references retrieved

Key points

- **For people with dual diagnosis, i.e. mental disorder and substance abuse, the current evidence on integrated (mental health care-substance abuse) residential treatment is inconclusive and more well designed controlled clinical trials are necessary (low quality evidence)**

4.3 MENTAL HEALTH SERVICES, OUT-PATIENT AND COMMUNITY

4.3.1 Mental Health Services, Out-patient and community, Emergency care (mobile/ non-mobile).

European Service Mapping Schedule (ESMS): (see ESMS tree)
Mental Health Services - Out-patient and community - Emergency care (mobile or non-mobile).

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

A. Cochrane and CRD database

Cochrane review by Irving (2006)[74] "Crisis intervention for people with severe mental illnesses".

Five studies were included. Participants were persons with severe mental illness, i.e. schizophrenia or other serious mental illnesses, however diagnosed; depressive crisis and substance abuse were excluded. Crisis intervention embedded in multi-disciplinary home care was evaluated versus acute hospital admission. None of these included studies purely investigated crisis intervention; all used a form of home care for acutely ill people, which included elements of crisis intervention. Also, none of the studies claimed that hospitalization could be entirely avoided; and admission to hospital was not considered to be a failure of community crisis intervention. Forty five percent of the crisis/home care group were unable to avoid hospital admission during their treatment period. Home care may help avoid repeat admissions but these data were heterogeneous.

No differences in death or mental state outcomes were found (although death might be a relatively poor informative parameter to judge overall crisis intervention results). Crisis/home care increases patient adherence, reduces family burden, and is a more satisfactory form of care for both patients and families. Data on cost effectiveness were inconclusive. Home care crisis treatment, coupled with an ongoing home care package, is a viable and acceptable way of treating people with serious mental illnesses. If this approach is to be widely implemented it would seem that more evaluative studies are still needed.

Berhe et al (2005)[75]: "Home Treatment für psychische Erkrankungen" (CRD-review DARE-20054489 in 2007): Literature review: acute care at home as compared to inpatient treatment is equally or more efficacious in respect to reduction of symptom distress, social (re-)integration and patient and carer satisfaction. Direct costs for home treatment were often lower than for inpatient care. However, the number of relevant studies (six) is limited and knowledge on the long-term effects is sparse.

Weinmann et al (2005)[76].

This systematic review, including SRs, RCTs and CCTs up to 2003, describes the results of the Cochrane review (Irving 2006).

B. Medline, PsycInfo, Embase

No additional references retrieved

Key points

- **There is evidence of moderate quality that home care crisis treatment, provided within other ongoing home care services, is an acceptable way of treating people with serious mental illnesses. No difference in death or mental health state is found as compared to acute hospital admission, but more studies, especially on long-term effects, are necessary.**
- **Crisis home care reduces family burden and is a more satisfactory form of care for both patients and families.**
- **It is not claimed that hospitalization can be entirely avoided; and admission to hospital should not considered to be a failure of community crisis intervention. Probably about half of the crisis home care patients are unable to avoid hospital admission at a certain point during follow-up, but further studies are necessary.**

4.3.2 Mental Health Services, Out-patient and community, Continuing care.

European Service Mapping Schedule (ESMS): (see ESMS tree)
Mental Health Services – Out-patient & community – Continuing care

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

The publications for this ESMS subdivision (paragraph 4.3.2) will be further classified as follows:

1. Community mental health care: efficacy/effectiveness
2. Case management: efficacy/effectiveness
3. Assertive community treatment: efficacy/effectiveness
4. Dual diagnosis: mental disorder and co-occurring substance abuse: efficacy/effectiveness of integrated community care

4.3.2.1 Community mental health care: efficacy/effectiveness

A. Cochrane and CRD database

Cochrane review by Malone et al. (2007)[40]: "Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality."

Community mental health care for people with severe mental illnesses, provided by a multidisciplinary team, was compared to usual care, i.e. non-team community care, outpatient care (ambulatory care organized at an hospital), admission to hospital, or day hospital. When at the same time ACT (assertive community treatment) or case-management was provided the study was not included. Participants were persons with severe mental illness, however defined in the included studies. Three studies (587 patients) were included, they all had been conducted in the UK.

CMHT management did not reveal any statistically significant difference in death by suicide. Significantly fewer people in the CMHT group were dissatisfied with services compared with those receiving standard care (RR 0.37 CI 0.2 to 0.8, NNT 4 CI 3 to 11). Also, hospital admission rates were significantly lower in the CMHT group (RR 0.81 CI 0.7 to 1.0, NNT 17 CI 10 to 104) compared with standard care. Admittance to emergency services, contact with primary care or with social services did not reveal any statistical difference between comparison groups. Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment.

It may also be superior in reducing hospital admission. The authors conclude that this evidence should be confirmed by other studies.

The results of the 2 following Cochrane reviews that compare day activities (transitional day hospitals, day hospitals providing day treatment programmes or day care centres) to usual outpatient care are mentioned in paragraph 4.4.3. (Day and structured activities), but their results can also be included here:

Cochrane review by Shek et al (2009)[77]: "Day hospital versus outpatient care for people with schizophrenia"

Cochrane review by Catty et al (2007)[78] "Day centres for severe mental illness"

In the first review (Shek 2009), two types of day hospital (or: partial hospitalization programs) as an alternative to out-patient care (but not inpatient care), are covered: 'day treatment programmes' and 'transitional' day hospitals. Day treatment programmes offer more intense treatment for patients who have failed to respond to out-patient care (usually patients with affective or personality disorders). Transitional day hospitals offer time-limited care to patients who have just been discharged from in-patient care. A third type, 'day care centres' are included in the second review (Catty 2007); day care centres offer structured support to patients with long-term severe mental disorders who would otherwise be treated in the out-patient clinic; they are mostly not run by hospitals or hospital staff.

It can be concluded from these reviews that insufficient evidence was found to determine whether day hospitals providing day treatment programmes, transitional day hospitals or (non-medical) day care centres have advantages over outpatient care for SMI persons.

Weinmann et al (2005)[76].

This systematic review, including SRs, RCTs and CCTs up to 2003, describes the results of 2 Cochrane reviews, and includes the results of the PRiSM-study conducted in the UK (see next paragraph.)

Burns et al (2001), Catty et al (2002)[30, 31] "Home treatment for mental health problems: a systematic review".

This review takes the Cochrane methodology as its starting point, but has a wider remit than usual, including high-quality non-randomized studies (prospective, with matched or equivalent groups). Comparative analysis was first conducted with the RCTs alone, and then repeated including non-RCTs of sufficient rigor. Studies were not confined to the patient group of severe mental illness: the majority of the participants had to be 18 to 65 years old with a `mental health problem'. Studies of substance abuse were excluded, except as a dual diagnosis. Home-based care (conducting treatment at home) was assessed against hospital care and against other forms of outpatient care. "Other forms of outpatient care" included any service that enables the patient to be treated outside hospital as far as possible and remain in their usual place of residence; included were assertive community treatment, intensive case management, case management, training in community living, and Community Mental Health Team care. The outcome parameter of interest was "days of hospital care" during follow-up. The meta-analysis was confined to a total of ninety-one studies, of which 56 were RCTs and 35 controlled studies. Eighty per cent of the studies had community controls and 20% in-patient controls. Over a quarter of the studies were carried out in the UK, and over half in the USA. The study inclusion criteria did not focus on the patient group of severe mental illness; but 87 studies focussed on people with psychotic disorders.

Studies comparing home treatment with in-patient hospital controls found a greater reduction in the mean number of hospital days during follow-up in favour of home treatment, than did those comparing home treatment with community controls. For studies of all duration of any time, there were 3.31 fewer days per patient per month compared with in-patients, and 0.40 fewer days compared with community controls. For studies of duration of at least 1 year, the differences were 4.75 days for in-patient control studies and 0.13 for community controls.

The only service components of home-based care that were significantly associated with reduced hospital time for community-control studies were 'regularly visiting patients' and 'responsibility for both health and social care'. The authors concluded that benefit of home treatment over admission in terms of days hospitalised was clear, but that it was inconclusive in relation to other community-based alternatives.

Additionally, a 3-round Delphi exercise ascertained consensus among 11 expert psychiatrists on the important components of community-based services that enable them to treat patients outside hospital. Six categories (including 16 items) were identified: skill-mix, psychiatrist involvement, service management, case load between 15-25, flexible working hours over 7 days (but not necessarily 24-hours), and home visit (but teams need not to be dedicated to home treatment). The teams in the included publications were fairly heterogeneous as to these 6 main components.

Of interest is also the comment, made by the authors in 2002 (Burns 2002)[79], that the supposed "active ingredients" of effective home interventions overlap with (but are not identical to) the basic principles of ACT (see also paragraph 4.3.2.3).

It should be kept in mind that most studies were performed in the USA or in the UK, and local or international contexts can affect extrapolation of findings to different settings. Therefore, the authors performed separate analyses to compare results for USA-based versus European-based studies (Burns 2002)[79, 80]. It appeared that USA-based studies found a larger reduction in hospital days than European-based (mostly UK) studies, which could not be attributed not to differences between the experimental service provision in the two parts of the world. It seemed that there was a difference between the control groups in the USA and Europe, such that European control services seemed to be closer to experimental services.

It is interesting to note that the authors, who could contact about 60% of the authors of the included publications, found out that less than 50% of the teams described by these authors were still identifiable, and less than 25% of the teams were still enduring in approximately their original form, without having dropped their 'innovative' features. This raises questions as to the sustainability of these services.

B. Medline, PsycInfo, Embase

Whereas the Cochrane study on CMHTs (Malone 2007)[40] focused on the comparison of CMHTs to non-team mental health care, other aspects of CMHTs were highlighted in studies not included in the Cochrane evaluation.

PriSM Psychosis Study (1998), see also Weinmann et al (2005)

In this study (Thornicroft 1998, Taylor 1998, Leese 1998, Wykes 1998, Johnson 1998, Thornicroft and Wykes 1998, Becker 1998)[81-87], patient outcomes at two UK urban socio-demographic matched catchment areas (each 40 000 inhabitants) were compared before and after implementation of a Community mental health service (CMHS). In area one, the CMHS was an intensive service with two specialist teams (one for acute and one for continuing care); in area two, it was a standard service with a generic team.

In these catchment areas, a random sample (N=302) of all psychotic (as a proxy for SMI) persons, their carers and responsible staff were interviewed at baseline (while psychiatric services were largely provided on a hospital-base) and after two years. Outcomes were evaluated in the domain of psychiatric symptoms, social functioning and social networks, (un-)met needs, quality of life and satisfaction with services. Outcomes for both types of CMHS were better than for the baseline hospital-oriented service. No evidence was found that community-oriented services (including community in-patients beds) fail service users, their family or the wider public. This trial confirmed that the health and social gains reported in experimental trials of CMHS can be replicated in ordinary clinical settings. When comparing area one and two, some very limited extra advantages in terms of met needs, improved quality of life and social networks, were found in the intensive CMHS; but the general CMHS was almost as effective (and less expensive in the context of the UK service system). It was noted in this study that at the two catchment areas, only 9% of the included persons were full-time at work.

Killaspy et al (2006)[88] conducted a RCT to compare CMHTs with ACT (see further). In this study in London, 251 SMI persons were involved. After 18 months, no difference was found in inpatient bed use or in clinical or social outcomes for the 2 treatment groups. However, ACT seemed better to keep contact with difficult-to-engage persons, and client satisfaction with services was greater.

UK700 study (Burns 2000): see further

- **For people with severe mental illnesses Community mental health team management is not inferior to non-team standard outpatient or hospital care and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission. However, this evidence coming from UK trials only should be treated with caution, and further research is necessary.**
- **There is insufficient evidence to determine whether day hospitals providing day treatment programmes, transitional day hospitals or (non-medical) day care centres have advantages over outpatient care for SMI persons.**
- **Home-based treatment for mental disorders can reduce the number of days spent in hospital during follow-up, when compared to hospital based care. The difference between home-based care and other forms of outpatient care is less clear. Evidence for this conclusion is of moderate quality.**
- **Factors associated with this reduction in hospital days for home-based treatment were "regularly visiting patients" and "responsibility for both health and social care".**
- **At the time of the systematic review on home-based treatment, less than 50% of the teams of the original studies still existed. This raises questions as to the sustainability of these services.**
- **Many of the included studies were performed in the USA or the UK, so extrapolation toward other countries should be done with caution.**

4.3.2.2 Case management: efficacy/effectiveness

A. Cochrane and CRD database

Cochrane review by Marshall et al (1998)[89]: "Case management for people with severe mental disorders."

Participants were persons with severe mental illness, i.e. schizophrenia and schizophrenia-like disorders, bipolar disorder, depression with psychotic features, or dually diagnosed persons (severe mental illness plus substance abuse). Ten studies were included. When compared to standard community treatment, results showed that case management increased the numbers remaining in contact with services (OR = 0.70; 99%CI 0.50-0.98; NNT 15) but approximately doubled the numbers admitted to psychiatric hospital (OR 1.84; 99% CI 1.33-2.57). Case management showed no significant advantages over standard care on any psychiatric or social variable, except on compliance (one study). Cost data did not favour case management but insufficient information was available to permit definitive conclusions.

The authors conclude that case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services.

Ziguras et al (2000)[33]: "A meta-analysis of the effectiveness of mental health case management over 20 years."

In this meta-analysis, both studies on assertive community treatment (ACT, see further) and case management were included, since ACT was considered to be a specific kind of case management. There were no restrictions on study design, other than limiting inclusion to comparative studies. Studies for which an effect size or p-value could not be calculated, were excluded from the analysis. Forty-four relevant studies were identified, including 35 comparisons (29 RCTs) of usual treatment with either assertive community treatment (19 studies) or another model of case management (16 studies). Nine studies (7 RCTs) directly compared assertive community treatment with another model of case management. The approach used for study selection and quality assessment provided very limited information. Heterogeneity between studies was tested; some evidence of publication bias was found in the analysis.

The authors also carried out a sensitivity analysis that excluded non-randomized studies; the remaining randomized studies were more homogenous and the results were similar to the overall pooled data.

Assertive community treatment and "standard" case management both led to small to moderate improvements in the effectiveness of mental health services. The two approaches had similar effects in improving clinical symptoms, the patient's level of social functioning, as well as patient and family satisfaction with services. Assertive community treatment had some demonstrable advantages over clinical case management in reducing hospitalization, both in terms of the proportion of patients admitted and the total length of stay. Case management led to more hospital admissions than usual care, but these admissions were shorter, which also reduced the total number of hospital days.

Weinmann et al (2005)[76].

This systematic review, including SRs, RCTs and CCTs up to 2003, describes the results of the Cochrane review and the review by Ziguras et al (ref), and included also the results of the UK700-study (see next paragraph)

CRD-review: Gensichen et al (2006)[90]: Case management to improve major depression in primary health care: a systematic review.

Studies assessing case management as a community-based intervention in primary health care settings were eligible for inclusion. Thirteen RCTs were included. The complexity and nature of the interventions varied and was scored by a published complexity score, examining the number of elements included in the intervention. The review concluded that case management is an effective strategy in the treatment of major depression in primary health care settings, improving clinical response, symptom scores and remission rate.

Overall, the findings appear to support the intervention, but some caution is advised given the differences between studies. However, the evidence is insufficient to recommend 'complex' case management over 'standard' case management. The majority of the studies were conducted in the USA, and further research is required to investigate the effectiveness of case management in other health care systems.

B. Medline, PsycInfo, Embase

Burns et al (1999), Walsh et al (2001) and Burns et al (2000)[91-93] describe the results of the UK700-study, a large UK randomized controlled trial comparing standard case management (SCM, case-load >30) and intensive case management (ICM, case-load 10-15) for 708 persons diagnosed with psychotic symptoms and SMI (UK700 trial) (ref, ref). No significant differences were found at 2 year follow-up between the two groups for rate of suicide, rate or duration of hospital admission, clinical outcome, social functioning including living independently, days in jail, quality of life, number of unmet needs, or patient satisfaction with health services. At 1 year follow-up there were significantly less clinical symptoms and unmet needs in the ICM group, but this had disappeared by two years. Counter-intuitively, significantly more patients lost contact with their case manager in ICM than in SCM. Many other studies found differences in favor of intensive approaches; however this was not confirmed in this trial. The authors conclude that future investment should aim at the specific content of care rather than at its form and delivery.

Bjorkman et al (2002)[94] describe the results of a Swedish RCT on case management (strengths model) versus standard care, including 77 SMI persons. After 36 months, they found no differences in clinical or social outcome. However, CM was successful in reducing days spent in hospital, and the clients were also more satisfied with the service compared to standard care. Bjorkman et al (2007)[95] re-evaluated the initial cohort six years later, and found a decrease in use of psychiatric services and sustained improvements in social functioning.

Ford R et al (2001)[39] conducted in the UK a multi-site 5-year follow-up study of people with severe mental illness. From 0 to 18 months all three sites had Intensive Case Management (ICM) teams practising assertive outreach. From 18 to 60 months one team sustained ICM, one team merged and another was disbanded. All original ICM team clients still alive at 60 months FU were the study participants (N=120); no differences were found between the 3 sites in clinical or social outcome or in number of clients dropped out of contact with services. The authors conclude that ICM might not be necessary in the long term since the varied service models appeared to achieve similar outcomes. Procedures should be developed to transfer people after a certain time form ICM to lower intensity care.

Key points

- **There is moderate quality of evidence that case management can ensure that more people remain in contact with psychiatric services (one extra person remains in contact for every 15 people who receive case management).**
- **However, it increases hospital admission rates (moderate quality of evidence); more good quality studies are necessary to judge whether length of stay diminishes.**
- **Evidence on its effects in improving clinical symptoms or the patient's level of social functioning, is conflicting.**
- **Many forms of case management exist, and the complexity and nature of the interventions varies. Evidence is insufficient to recommend 'complex' case management over 'standard' case management.**
- **The majority of the studies were conducted in the USA or the UK, and further research is required to investigate the effectiveness of case management in other health care systems.**

4.3.2.3 Assertive community treatment: efficacy/effectiveness

A. Cochrane and CRD database

Cochrane review by Marshall et al (1998)[36]: "Assertive community treatment for people with severe mental disorders."

Participants were persons with severe mental illness, however defined in the included studies. Twenty studies were included. ACT was compared to outpatient clinics or CMHT (standard community care). People receiving ACT were more likely to remain in contact with services (OR 0.51, 99%CI 0.37-0.70; NNT=9) and less likely to be admitted to hospital than those receiving standard community care (OR 0.59, 99%CI 0.41-0.85; NNT=10). Significant and robust differences between ACT and standard community care were found for accommodation status (living independently, NNT=7), employment (NNT=7), and also for patient satisfaction (2 studies only). There was no clear difference between ACT and standard community treatment on the outcomes of death or clinical symptoms, and of social functioning. ACT was also compared to hospital-based rehabilitation services delivered to ambulatory patients. Those receiving ACT were no more likely to remain in contact with services but were significantly less likely to be admitted to hospital (OR 0.2, 99%CI 0.09-0.46). Those allocated to ACT were significantly more likely to be living independently (OR 0.19, 99%CI 0.06-0.54).

For the comparison of ACT to case management, there were no data on numbers remaining in contact with the psychiatric services or on numbers admitted to hospital, but people allocated to ACT spent fewer days in hospital than those given case management. There were insufficient data to permit robust comparisons of clinical or social outcome.

It should be noted that the publication on this topic of the Danish Institute for Health Services Research (DSI) (1999)[m] and "Gezondheidsraad" or the Health Council of the Netherlands (2004)[n] are largely based on this Cochrane report.

Conseil d'évaluation des technologies de la santé du Québec (AÉTMIS, 2001)[96]: "Assertive community for people with persistent and particularly severe mental illness"

In this report, the authors state that ACT is only intended to serve adults with severe mental illness who have considerable difficulties, most often manifested by psychotic symptoms, poor response to usual services, and repeated hospitalizations. According to their estimations, this population represents only 0.7 to 1 person in 1,000 on average – thus a small minority, 10% at most, of those with severe mental illness. This report also proposes a number of organizational, technical and financial means to facilitate the introduction of ACT services in Quebec.

The literature review in this report is based on the Cochrane review (1998), the review of Mueser et al. (1998)[97] and an older review of Scott LE and Dixon LB (1995). For the period from 1995 to 1998, a computerized search using Medline, PsycInfo and Embase was conducted. Experimental and quasi-experimental studies were included, as well as some references belonging to the "gray literature". The conclusions of this report are in agreement with the conclusions of the Cochrane review (Marshall 1998)

Weinmann et al (2005)[76].

This systematic review, including SRs, RCTs and CCTs up to 2003, describes the results of the Cochrane review (Marshall M 1998)[36], and includes also the results of 3 additional RCTs.

The 3 RCTs describe results after a 2-year follow-up period; the first by Harrison-Read et al (2002)[98] in London (UK); the second RCT by Clarke et al (2000)[99] in the USA; and the 3rd RCT by Dekker et al (2002)[100] was conducted in the Netherlands (Amsterdam). In the London study (Harrison-Read et al, 2002), no clinical or functional differences are found between ACT and usual care, despite a 2.4 fold increase in community contacts in the ACT group.

In the USA-based study by Clarke et al, no differences are found between ACT and usual care in time to first psychiatric hospitalization, emergency room visit and homelessness, although the time to first police arrest is increased in the ACT group. The ACT group consisted of two subgroups: consumer-staffed and non-consumer-staffed ACT teams. SMI persons from the non-consumer-staffed ACT team experienced a significantly shorter time to first hospitalization, were more often hospitalized and visited more often an emergency room. In the study by Dekker et al, the ACT program reduces strongly the number of days in hospitalization but there is no difference in every day functioning as compared to usual care. Weinmann et al[76] conclude that these recent studies show that since the start of ACT in the1970s, some of its principles might have been passed on to routine care, especially in England.

CRD-review (DARE- 983570 in 2007): Mueser et al (1998)[97]

Literature review includes 32 RCT's on standard case management, rehabilitation-oriented community care, intensive comprehensive care (assertive community treatment (ACT) and intensive case management (ICM)); however, validity of the included studies is not assessed. ACT and ICM reduce time in hospital and improve housing stability, especially among patients that are high service users. ACT and ICM appear to have moderate effects on improving clinical symptoms and quality of life. Most studies suggest little effect of ACT and ICM on social functioning, arrests and time spent in jail, or vocational functioning.

Studies on reducing or withdrawing ACT or ICM services suggest some deterioration in gains. Research on other models of community care is inconclusive.

Cochrane review by Marshall et al (2009)[101]: "Early intervention for psychosis"

m http://www.dihta.dk/projekter/60_uk.asp
n http://www.gr.nl/adviezen.php?ID=972

The onset of psychosis, typically in young adulthood, is usually preceded by a period of non-psychotic symptoms, known as prodromal symptoms. Early intervention has two objectives: the first is to prevent the onset of schizophrenia in people with prodromal symptoms; the second is to provide effective treatment to people in the early stages of schizophrenia, with the goal of reducing the ultimate severity of the illness. The Cochrane review included 7 RCTs (literature up to August 2006); none of the studies had similar interventions. All but one evaluated several treatment options, such as medication, cognitive behavioural therapy and family therapy against each other or against usual care; these trials, all including a limited number of participants (less than 83), are out of the scope of this report.

One large study, the Scandinavian OPUS study (Bertelsen 2008)[102], included 547 first episode schizophrenia patients and allocated them to "*integrated treatment*" (ACT plus family therapy, social skills training and a modified medication regime) or standard care. Global state outcome GAF significantly favored integrated treatment (n=419, WMD -3.71 CI -6.7 to -0.7) by one year, but by two years data were non-significant. Rates of attrition were significantly lower (n=547, RR 0.59 CI 0.4 to 0.8, NNT 9 CI 6 to 18) for integrated treatment by one and two year follow-up. The authors conclude that insufficient trials were identified to draw any definitive conclusions.

B. Medline, PsycInfo, Embase

Tibbo et al (1999)[103] conducted a pre-post study of 295 persons with SMI in Canada, comparing their hospital admissions before and 1 year after their involvement in ACT. They confirm the conclusions of the Cochrane review, as to reduction of emergency room visits, hospital admissions and length of stay. The pre-post study by Udechuku et al (2005)[104] of 43 persons with SMI in Australia also found reduction in readmission days after the start of ACT. The quality of these 2 studies is weak; they are presented because they contain an evaluation of ACT in a naturalistic clinical environment.

Smith et al (2007)[35] conducted a systematic review for case management and selected 39 papers on studies conducted between the 1970s and 2002. The large part of the studies involved Intensive case management (ICM) (15 papers) and ACT (10 papers), the rest of the experimental conditions were standard CM or other variants of CM. The terms ICM and ACT appeared often to be used loosely and interchangeably. Comparators were standard CM, other variants of CM, hospital-based rehabilitation (one study) and standard care.

The authors described the results qualitatively. The four most commonly described outcomes were hospital admissions, total days admitted, symptom reduction and quality of life (QoL). For hospital admissions and total days admitted, the results were not consistent (decrease, no change or increase). Symptom reduction and QoL were either improved or there was no significant difference. In the domains of engagement in therapy, employment, and independent living the results were consistently positive, but the number of studies examining these outcomes was small (2-5 studies). The authors observe that the benefits of the experimental conditions over the control conditions diminished over time. First, as time evolves the control condition more often becomes "standard CM". Second, the authors speculate that "standard care" has developed to resemble CM or ACT. Firm conclusions remain difficult due to poorly defined treatment conditions in many studies, and because of differences between studies due to local implementation factors.

The Dutch RCT by Sytema et al (2007)[105], including 118 SMI persons, confirms the results of the Smith review, in that the use of in-patient care was not significantly reduced; neither were there important clinical or functional gains. However, maintaining contact with difficult to engage SMI persons was improved by ACT as compared to standard care.

Burns et al (2007)[106] conducted a meta-regression to explore which factors contribute most to a decrease in days of hospital admission when Intensive case management ICM or ACT (terms used interchangeably) is offered to persons with SMI. They conducted a systematic review and included 29 existing clinical trials. Authors were contacted for levels of staffing and fidelity rating of the team to the ACT model; for rating of CM involvement in the control condition, and for initial data-sets. In the meta-regression analysis these factors were tested on their correlation with decrease in days of hospital admission; the other factors were the base-rate hospital use and mean days of hospital use in the control group, the study year (assuming that effects might be more prominent in older studies), the country (USA or non-USA), and the trial size. Only for base-rate hospital use (mean days admitted 2 years before the study) or hospital use in the control groups, and for fidelity to the ACT model, statistical significance was reached. The result for the latter was less robust in sensitivity analyses. The authors conclude that ICM/ACT works best when participants tend to use a lot of hospital care and less when they do not. However, according to Rosen et al (2008), it might be difficult to conclude firmly on the factor "fidelity to the ACT model" and "levels of staffing", since these were based on retrospective fidelity ratings and recall of the original investigators (Rosen 2008)[107]. The same holds true for "CM in control treatment".

Coldwell et al (2007)[108] conducted a systematic literature review and meta-analysis to evaluate the effectiveness of ACT for homeless people with SMI. Six RCTs (five of which are also included in Nelson et al (2007)[70]) and 4 observational pre-post studies were included, all but 1 study were from the USA. ACT participants experienced significantly greater success in reducing homelessness (8/10 studies, 4/6 RCTs) but not in reducing hospitalization (2/5 studies, 1/4 RCTs). ACT participants experienced significantly larger reduction in psychiatric symptoms (4/6 studies, 2/3 RCTs). The summary effect size (random effects method) for homelessness (RCTs) is 37% (95% CI=18-55; p=0.0001); the summary effect size (random effects method) for symptomatology (RCTs) is 26% (95% CI=7-44; p=0.006). Five of the six included RCTs are also included in Nelson G 2007 and in Hwang S 2005 (see higher); conclusions are in line.

Krupa et al (2005)[109] organized focus groups with 52 SMI participants to describe the perspective of ACT service users in Canada. Overall, participants were positive about their involvement with ACT and their experiences reflected the critical ingredients that the model aims at. Based on an intense, continuous one-to-one relationship with a primary worker and a relationship with the team, ACT helped its service users with meeting daily practical challenges and it eased the problems associated with living in poverty on a disability pension. It engaged them in treatment, offered interventions related to management of the disorder, and supported them in crises. Overall, services promoting community participating were less well developed than clinical approaches. Tensions inherent in receiving ACT services were related to the participants' negotiation of personal and social consequences of mental illness while striving for autonomy and community participation (e.g. conflicts over medication or money, feeling stigmatized because of receiving ACT services). According to the service users, staff required more training in particular service areas, and occasionally authoritative practices were noticed which should be avoided.

C. ACT: General information and discussion

The results of Smith et al (2007) and Weinmann et al (2005)[35, 76], seem to point to an evolution over time in outcome results, for both ACT and ICM. Studies conducted in the 1970s showed overwhelmingly positive findings for the experimental groups over standard care. Studies conducted since then have had less favourable results with a mix of improvements in some domains and no significant change in other domains. Likewise, there seems to be a trend of different experiences of Europeans and North Americans with ACT and ICM (Burns 2000 and Burns 2001)[80, 92, 110], with results being less prominent in European studies[111], as it was also found for home treatment (see higher, Burns et al 2002)[79, 80].

Without being exhaustively, and in line with the issues discussed in paragraph 2.4, an explanation for this might be that local resources, infrastructure, national policy and other systemic issues have real interactions with how ACT and ICM are practised. These factors are no constants and as policy and resources change, there will be inevitably an impact in clinical settings. This is clearly illustrated by Fioritti et al (2002)[112], who compare an ACT team in Bologna, Italy, with an ACT team in London, UK.

All these factors were explored by Burns et al (2007)[106] in a meta-regression of existing studies on ICM or ACT for SMI persons; dependent variable was days of hospital admission. The decrease in days of hospital admission was most strongly associated with intensity of hospital use before the start of the trial, and was not related to country or time of study conduct. The factors "fidelity to the ACT-model", "level of staffing", or "use of CM in the control group" relied on retrospective data only and might need further exploration.

Priebe et al (2003)[38] evaluated the working modalities of Assertive outreach teams (AOT). In England, the provision of AOT by the CMHTs is obligatory since 1999; they aim to serve the subgroup of SMI persons whose needs the CMHTs struggle to meet. Priebe et al conducted semi-structured interviews with 24 AOT in London and concluded that they appeared to work much in an ACT-like way although there was a wide variation in their practices. The population these AOT worked with is described. Commander et al (2005)[113] also describe the 2-year follow-up of a cohort of 250 SMI persons involved in assertive outreach services in North Birmingham. Note that in the study of Ford et al (2001)[39], already discussed before, the term "assertive outreach" is more close to the concept of case management.

Cuddeback et al (2006), van Veldhuizen (2007)[114, 115]

In a narrative review of low quality, an interesting question is raised by Cuddeback et al (2006) as to how many ACT teams are needed nationwide. The review describes that many authors agree on the fact that it is not necessary to provide ACT for all persons with severe and persistent mental illness. Rather, in the context of the USA, ACT eligibility is typically defined as having a severe and persistent mental illness, *and* a minimum of two or, according to some authors, three psychiatric hospitalizations within the past year. According to Cuddeback, this is estimated at 20 to 50 percent of all adults with SPMI. The AETMIS review (see before), also estimates that only 10% of SMI persons need ACT.

On the contrary, van Veldhuizen (2007) argues that, in the context of the Dutch health care system, a more extensive model of ACT can be beneficial for all persons with SMI, including those in a more stable illness phase.

The interested reader, who wants to know more on practical and operational issues concerning ACT, is referred to Phillips et al (2001)[116].

Key points

- **People receiving ACT are more likely to remain in contact with services as compared to standard community care but not hospital-based rehabilitation (moderate quality evidence).**
- **There is moderate quality of evidence from one Cochrane review (1998) that ACT, when compared to standard community care or hospital-based rehabilitation, can reduce hospitalizations in SMI persons.**
- **However, in more recent studies, control conditions could also include some form of case management (CM), and results seemed to be less prominent in European countries as compared to the USA.**
- **A meta-regression (2007) demonstrated that the variable "days admitted to the hospital" is dependent on the intensity of hospital use before the start of the trial: ACT works best when participants tend to use a lot of hospital care and less when they do not. No relationship with country or year of study (old or more recent study) was found.**
- **ACT, compared to standard community care or hospital-based rehabilitation, can improve accommodation status (living independently) and employment (moderate quality evidence).**
- **ACT provides significant better client satisfaction (2 trials); results on quality of life are divergent.**
- **There was no clear difference between ACT and standard community treatment on death, clinical symptoms or social functioning (moderate quality evidence).**
- **Available evidence does not suffice to indicate whether ACT teams should be based in hospitals or in community organizations.**
- **One qualitative study concludes that overall, SMI persons are positive on their involvement with ACT.**
- **One large Scandinavian study on "Early psychosis intervention" implemented an integrated treatment including ACT, but more evidence it needed before final conclusions can be made.**

4.3.2.4 Dual diagnosis: mental disorder and co-occuring substance abuse: efficacy/effectiveness of integrated care

A. Cochrane and CRD database

Cochrane Review by Cleary et al (2007)[73]: "Psychosocial treatment programmes for people with both severe mental illness and substance misuse".

For a variety of reasons, the frequency of co-occurring substance abuse among people with severe and persistent mental illness is high. Abuse of drugs or alcohol in this vulnerable population increases their risk of adverse outcomes, such as non-adherence to treatment, relapse, suicide, hepatitis and HIV, homelessness etc. Treatment programs for substance abuse and for mental disorders traditionally differ in their theoretical underpinnings, protocols, and service supply. Therefore it has been suggested that providing both therapeutic approaches to "dual-diagnosis" patients in a coordinated way by integrated services, might yield better results than providing each service separately. Cleary et al (2007) evaluated 4 RCTs (N=735) on integrated care for substance abuse and mental disorders, based on the "integrated team" philosophy: the same clinicians or teams of clinicians provide long-term treatments in a coordinated fashion, which means that the services should appear seamless to the client with a consistent approach, philosophy and set of recommendations. More-over, this type of care also included outreach to engage patients, as described in the ACT model. As compared to usual care, no difference was noted by 36 months for loss to follow-up (4 studies) or substance abuse (1 study only) in the integrated program.

Two studies demonstrated an equal rate of hospitalization in both groups, and no difference in stable community residency at 36 months. The authors also described 4 other RCTs (N=151) on intensive case-management (ICM, case-load<15 patients), a non-integrated program including similar interventions as the integrated team approach except that services are not provided in a coordinated fashion and outreach is not included. Again, by 18 months follow-up no difference was noted as compared to usual care for substance abuse or loss to follow-up in the ICM program. It appears that so far for "dual diagnosis" mental health care patients, no data is yet available that demonstrates superiority of one type of treatment over another. The authors conclude that the current momentum for integrated programmes is not based on good evidence. More well designed controlled clinical trials are necessary.

CRD-review: Drake et al (2008)[34]

The focus of this review is the integrated treatment for dually diagnosed patients with severe mental illnesses and co-occurring substance abuse[117]. Search strategy is not described, however 8 reviewers evaluated the completeness of the review. Part of the review deals with team-based case management (ACT model) for persons with dual diagnosis, a narrative synthesis of 11 experimental or quasi-experimental studies is presented. The studies produced inconsistent results on substance abuse outcomes and mental illness symptoms, but results for increasing engagement, hospital use and quality of life outcomes were positive as can be expected from the ACT intervention. The authors conclude that traditional outcomes for ACT might be obtained with dual diagnosis patients as well. However, the effect on substance abuse probably depends on specific interventions included (or not) in the ACT service.

B. Medline, PsycInfo, Embase

No further references retrieved.

Key points

- **For people with dual diagnosis, i.e. mental disorder and substance abuse, the current evidence does not support integrated treatment in the community, but more well designed controlled clinical trials are necessary (low quality evidence)**

B. Medline, PsycInfo, Embase

No additional references retrieved.

4.4 MENTAL HEALTH SERVICES, DAY & STRUCTURED ACTIVITY

In the Table below, a scheme is presented to clarify which services belong to this subcategory (HEN July 2005°)(see also paragraph 4.3.2.1). Transitional day hospitals provide time-limited care for patients who have just been discharged from hospital. Day treatment programmes provide more intense treatment for patients who failed to respond to outpatient care. Day care centers offer structured support to persons with long-term severe mental disorders; they are mostly not run by hospitals or hospital staff.

° Marshall M (2005). How effective are different types of day care services for people with severe mental disorders? Copenhagen, WHO Regional Office for Europe; Health Evidence Network report; http://www.euro.who.int/Document/E87317.pdf.

Table 4.1 Classification of mental health services providing day and/or structured activity

	FUNCTION		
STRUCTURE	Alternative to inpatient admission	Shortening duration of inpatient stay	Recovery or/and maintenance
Psychiatric day treatment/care	Acute psychiatric day hospital	Transitional day hospital (non-acute)	Day centre (more intensive: day treatment; structured support only: day care)
Employment service	x	x	Vocational program (supported employment or pre-vocational training)
Social care facility	x	x	Drop-in centre

4.4.1 Mental Health Services, Day & structured activity, Acute.

European Service Mapping Schedule (ESMS):
Mental Health Services - Day & structured activity – Acute.

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

For treatment in day hospitals as compared to inpatient care, systematic reviews as well as RCTs were found. However, in these publications all types of acute psychiatric disorders were included and not only SMI persons in need of acute care. Since no separate evidence is available for the group of SMI persons, the evidence for all types of acute psychiatric disorders will be presented here.

A. Cochrane and CRD database

CRD-review (DARE-20011271 in 2007): Horvitz-Lennon et al (2001) "Partial versus full hospitalization for adults in psychiatric distress: a systematic review of the published literature (1957-1997)"[118].

These authors included 18 studies on adults (18-65 yrs) in acute psychiatric distress; the severity of illness in the participants varied widely. Persons with addiction problems were excluded. The literature search was poorly documented. Study types were 10 RCTs, 4 clinical trials, and 4 studies of another type; 11 studies were of fair and 2 of poor quality. Several methodological flaws were evident, e.g. lack of baseline comparability of groups, a mean baseline exclusion rate of 56% for the RCTs, high drop-out rates, heterogeneity of outcome measures etc. Effect sizes for each study were calculated or mathematically estimated. A meta-analysis was performed on the grouped studies and sensitivity analyses were performed. For clinical symptoms and social functioning, there was no difference between full or partial hospitalization in any of the reported effect measures.

In the short term (0-6 months after discharge) partial care appeared to significantly improve measures of social functioning but this was not retained in the long term (7-12 months or 13-18 months after discharge). Measures of satisfaction with services were in the advantage of partial care at 12 months after discharge. Given the methodological flaws, the authors recommended further research to confirm the results.

Cochrane Review by Marshall et al (2003)[119]: "Day hospital versus admission for acute psychiatric disorders".

Nine RCTs on adults (18-65 yrs) with acute psychiatric disorders were included; persons with primary diagnoses of addiction or organic brain disorder were excluded.

Between day hospital patients and controls, there was no difference in number of days in hospital (n=465, 3 RCTs, WMD -0.38 days/month CI -1.32 to 0.55); and there was no significant difference in readmission rates (n=667, 5 RCTs, RR 0.91 CI 0.72 to 1.15). Psychiatric symptoms of patients in day hospital care improved more quickly (n=407, Chi-squared 9.66, p=0.002), but this was not the case for social functioning (n=295, Chi-squared 0.006, p=0.941).

Combined data suggested that, at the most pessimistic estimate, day hospital treatment was feasible for 23% (CI 21 to 25) of those currently admitted to inpatient care, and at best for 38% (CI 35 to 40).

B. Medline, PsycInfo, Embase

Priebe et al (2006)[120]:

This RCT randomized 206 patients with acute psychiatric disorders of any type (excluding addiction) to conventional in-patient care or treatment in one London day hospital center. The first admission period of Day hospital patients was significantly longer, but they were no more likely to be readmitted. Day hospital patients had a significantly greater reduction in clinical symptoms at discharge even when taking into account their longer stay; this effect had disappeared 3 respectively 12 months after discharge. They reported a significantly higher treatment satisfaction at discharge and 3 months later, but there was no difference in quality of life at discharge or during follow-up. A limitation of this study is the low response rate at time of discharge (54%). The authors conclude that acute psychiatric day hospital may be an effective alternative to conventional in-patient care for patients in acute psychiatric distress (all diagnoses).

Kallert et al (2007)[121]: A multicenter RCT (EDEN-study) was conducted in 5 centers in different countries: the UK, Germany, Poland, Slovac Republic, Czech Republic. It studied effectiveness of acute day hospital versus inpatient treatment. Patient inclusion was not confined to SMI persons, but to all types of mental disorders excluding addiction; 1117 patients were included. Results show that acute psychiatric day hospital is as effective as in-patient care on clinical symptomatology, treatment satisfaction and quality of life. Overall level of treatment satisfaction differed according to the treatment center. Acute psychiatric day hospital is more effective on social disabilities at discharge and at 3- and 12-month follow-up. The first admission period was significantly longer for day hospital patients. In this study, it was estimated that day hospital treatment was feasible for 17% to 35% of those patients currently admitted to inpatient care. A separate analysis (Schützwohl 2005)[122] of German data on the burden on relatives (95 participants) did not show differences between day hospital and in-patient treatment.

Fairburn et al (2005)[123]: Treatment of anorexia nervosa (AN) is discussed, based on a systematic review by NICE on treatment of eating disorders (ref). No empirical evidence is available to support the use of any one treatment setting (inpatient, day patient, outpatient) over any other in terms of AN patients' outcome. The NICE review made the same conclusions for other types of eating disorders.

The research strategy used in this report yielded two articles of more recent date than the NICE review (Kong et al (2005)[124]: RCT, eating disorders, 43 participants, day treatment versus outpatient treatment; Zeeck[125] et al (2006): case-control study, anorexia nervosa, 26 participants, day treatment versus inpatient treatment). It is not possible to drawn further conclusions based on this limited evidence. Moreover, these disorders can present at adolescence as well as at adulthood. The search strategy used in this report (18-65 years) might be too limited to deal extensively with this topic.

Discussion

An interesting question has been raised by Marshall (HEN report 2005): "the key issue in the current debate over acute day hospitals is whether they still have a worthwhile role compared to more radical alternatives to admission such as crisis intervention and home based care. There is a clear need for research that focuses on direct comparisons of acute day hospital care with other alternatives to admission, and explores their role in modern community-based psychiatric services".

Key points

- **For persons with acute psychiatric stress (all diagnoses), day hospital treatment can be a valuable alternative to in-patient care.**
- **Results from several well-conducted trials in different countries and different health care contexts show that results on clinical symptoms, social recovery, quality of life and satisfaction with treatment are not worse compared to in-patient treatment.**
- **Length of day hospital stay seems to be on average longer than stay on a ward, but results from available trials are not fully convergent.**
- **Day hospitalisation is not a valid option for every patient. It is estimated that day hospital treatment is feasible for 1/5 to 1/3 of those currently admitted to inpatient care.**
- **There is a need for research that focuses on direct comparisons of acute day hospital care with other alternatives to admission such as crisis intervention and home based care.**

4.4.2 Mental Health Services, Day & structured activity, Non-acute, Work or work-related activity (high & low intensity).

European Service Mapping Schedule (ESMS):
Mental Health Services - Day & structured activity - Non-acute - Work or work-related activity (high & low intensity).

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

A. Cochrane and CRD database

Cochrane Review by Crowther et al (2001)[126]: "Vocational rehabilitation for people with severe mental illness"

People who receive supported employment are significantly more likely to be in competitive employment than those who receive pre-vocational training, as concluded from 18 RCTs. At 18 months, 34% of people in Supported Employment were employed versus 12% in Pre-vocational Training (RR random effects (unemployment) 0.76 95% CI 0.64 to 0.89, NNT 4.5). Clients in Supported Employment also earned more and worked more hours per month than those in Pre-vocational Training.

CRD review (DARE-970407): Bond et al. (1997)[127]: experimental and non-experimental studies, qualitative overview: people who receive supported employment are significantly more likely to be in competitive employment than those who receive pre-vocational training.

Weinmann et al (2005)[76]

This systematic review, including SRs, RCTs and CCTs up to 2003, describes the results of the Cochrane review (Crowther 2001), and includes also the results of one additional RCT by Lehman AF 2002. The latter study was conducted in the USA, and again emphasizes the advantages of supported employment. The reviews by Bond et al (2004)[128] and by Twamley et al (2003)[129] (retrieved in the Medlin search) make similar conclusions.

B. Medline, PsycInfo, Embase

Latimer et al (2006)[130] confirms the results from the reviews in a RCT including 150 SMI persons conducted in Canada.

Burns et al (2007)[131] performed a large multi-center RCT in 6 different European centres. In this study 312 SMI persons received IPS (individual placement and support) or standard vocational services. IPS linked with existing CMHTs in charge of SMI persons and helped SMI persons that wanted to re-enter in the competitive labour market to find appropriate employment directly; IPS developed a network of employers willing to accept patients and supported also these employers. Standard services included a training program at combating deficits regarding to working skills, followed by help to find a job. IPS was clearly superior in number of patients starting a job, and in length of job tenure. SMI persons in the control group were more likely to drop-out. Local unemployment rates accounted for heterogeneity in the outcomes.

Leff et al (2005)[132] further elaborate on the relative role of several aspects of IPS, in the context of the US labour market. Cook et al (2005)[133] evaluated 1273 SMI persons receiving vocational and psychiatric services. Integrated "vocational-psychiatric" services seemed more effective, but this conclusion might have been confounded by the fact that less severely involved SMI persons received more vocational services.

4.4.3 Mental Health Services, Day & structured activity, Non-acute, Other structured activity, (high & low intensity).

European Service Mapping Schedule (see ESMS):
Mental Health Services - Day & structured activity - Non-acute - Other structured activity (high & low intensity).

SECURE			
RESIDENTIAL	Generic acute	Hospital	
		Non-hospital	
	Non-acute	Hospital	Time limited
			Indefinite stay
		Non-hospital	Time limited
			Indefinite stay
DAY & STRUCTURED ACTIVITY	Acute		
	Non-acute	High intensity	
		Low intensity	
OUT-PATIENT & COMMUNITY	Emergency care	Mobile	
		Non-mobile	
	Continuing care	Mobile	
		Non-mobile	
SELF-CARE & NON-PROFESSIONAL			

A. Cochrane and CRD database

The results of the following Cochrane review that compares day activities provided in day care centres to usual outpatient care are also mentioned in paragraph 4.3.2.1 (Community mental health care); the distinction with transitional day hospitals and day hospitals providing day treatment programmes is described in paragraph 4.4.

Cochrane review by Catty et al (2007)[78]: "Day centres for severe mental illness".

In this review, all day care centres linked to hospitals were excluded, and only "pure" non-medical day care centres were taken into account. No trials could be selected, hence no evidence is available.

B. Medline, PsycInfo, Embase

No additional references

Key points

- **Insufficient evidence is available to determine whether day hospitals providing day treatment or transitional day hospital care have advantages over outpatient care for people with schizophrenia or other similar mental illness.**
- **There is also insufficient evidence to judge on the outcomes of day care centres for this group of persons.**

4.4.4 Mental Health Services, Day & structured activity, Non-acute, Social support, (high & low intensity).

European Service Mapping Schedule (ESMS):

Mental Health Services - Day & structured activity - Non-acute - Social support (high & low intensity).

A. Cochrane and CRD database

Cochrane review by Buckley et al (2007)[134]: "Supportive therapy for schizophrenia".

This review defines "supportive therapy" as a therapeutic element, most often (but not always) classified in the group of psychotherapy. Treatment by face-to-face therapy is out of scope of this report.

B. Medline, PsycInfo, Embase

No additional references that specifically refer to organizational aspects of social support (and not to the therapeutic aspect).

4.5 CONTINUITY OF CARE, SERVICES & SYSTEMS INTEGRATION, CARE PROGRAMS

Although not belonging to the ESMS tree, this paragraph is added because it spans the different ESMS categories, and because it is a special matter of interest for this study (see chapter 1 "Research questions".)

4.5.1 Continuity of care

A. Cochrane and CRD database

No references retrieved

B. Medline, PsycInfo, Embase

The amount of studies addressing the relationship between continuity of care (CC) and patient outcome for SMI persons, is rather limited and characterized by an enormous heterogeneity. To understand this, one should keep in mind that continuity of care is a complex concept comprising many aspects which are not always easy to measure, or to standardize across studies (see definition of CC). Likewise, patient outcomes ideally should be measured along several dimensions, and very little studies address a comprehensive range of outcome parameters. Further, the relationship between service provision, continuity of care and patient outcomes is probably very complex and determined by many other factors, which should be taken into account as well. This makes it very difficult to measure a direct relationship between patient outcomes and continuity of care.

Nevertheless, an overview of the studies that attempted to address this difficult subject is given in the next paragraph.

Adair et al (2003)[52] included quasi-experimental, cohort and pre-post studies up to June 2002 in a systematic review about effects of continuity of care (CC) on *outcomes* for SMI persons. He concluded that the result from the SR was compromised by the heterogeneity of the included studies and by the limited aspects of CC that were measured whereby a diversity of evaluation instruments were used. The evidence on effects of CC on symptom control, patient functioning and quality of life remained limited showing positive effects in 2 studies but not in 3 other (among which the large-scale RWJF program, see also next paragraph). Examples of included studies are Bindman et al (2000)[135] and Saarento et al (1998)[136-139].

In 2005, a prospective cohort study was performed by Adair et al[57] who evaluated continuity of care by using a new evaluation instrument, the Alberta continuity of services scale for mental health (ACSS-MH). This instrument includes a CC evaluation by a professional as well as by the service user himself. For 486 SMI persons with stabilized illness, results of the ACSS-MH were compared with patient outcomes.

A significant association was found between patient-rated continuity (ACSS-MH) and quality of life, functioning as well as service satisfaction; and between observer-rated continuity (ACSS-MH) and quality of life as well as service satisfaction (significant at 0.01 level). No association was found with severity of clinical symptoms. However, the observational nature of the study does not allow to draw definitive conclusions on the causality of this relationship between CC and quality of life and service satisfaction: it is possible that persons who have better functioning and quality of life are more capable of continuity-maintaining behaviors.

Two later published studies on the relationship between patient outcome and CC are not reported here but are excellent examples of the many difficulties that are encountered while evaluating this type of interventions (Greenberg 2005, Forchuk 2005)[140-142]; details can be found in the Appendix. The same holds true for the review by Klinkenberg et al (1996)[143] (see also Appendix).

Crawford et al (2004)[54] conducted a systematic review of meta-analytic, experimental, observational and qualitative research, including literature up to Sept 2001. This SR examined *what factors interfere* with (promote or hinder) the delivery of continuity of care for SMI persons. Continuity of care (CC) was defined as: loss-to-follow up, breaks in service delivery, CC from a particular professional, CC between service components, service users' perception of CC.

Sixty papers were included. However no quality appraisal of the included papers was performed, which impairs the quality of this SR. Nevertheless the most important results are reported below, since Crawford was the only author including qualitative research on this subject (more details can be found in the Appendix).

Whereas for SMI persons *patient-related factors* associated with improved CC, (especially decrease in loss-to-follow-up) are rather well-established, *service related factors* have been less studied. Moderate quality of evidence exists only for a decrease in loss-to-follow-up by service-related interventions such as ACT, case management, CMHTs and crisis interventions. Whether ACT and case managers lead to more CC from a particular professional or not, is not known. A moderate level of evidence comes from a RCT and from several observational studies, that preparing discharge from hospital by patient training or by contact with an out-patient professional while still in-patient, improves loss-to-follow-up. Service related factors associated with better CC between service components are poorly studied, but it seems that effects of one possible intervention, namely information and training for general practitioners, are not straight-forward (1 RCT). There is a high level of evidence from a Cochrane review and one RCT that in the group of SMI-persons shared-care records do not enhance or facilitate communication. Interesting are the results from 2 qualitative studies (including 30 respectively 16 service users) that conclude that service users' perception of CC is better if they have the opportunity to build a long-term therapeutic relationship with one professional, if "contextualising" takes place (which means that professionals who have known the patient for a long time help other professionals to reframe the problems in the same way), and if key-workers are willing to adopt a flexible approach to care.

Conclusion on Continuity of care

Continuity of care is widely considered to be an important element of contemporary care for mentally disordered persons, especially for those with long-lasting mental illnesses, and CC measures are even used as performance indicators (Greenberg 2005)[141, 142]. Nevertheless, research to date, which remains of low quality due to implicit methodological problems, has not shown that continuity of care either by itself or in interaction with other features of service delivery ultimately improves clients' well-being as defined by symptom control, functioning or quality of life.

Whereas measures of CC can be useful in evaluating changes in the process of care, they are not straightforwardly related to individual outcome.

Until recently CC studies mostly used a provider-point of view, but two recent qualitative studies evaluate CC from the service users' point of view, including 30 respectively 16 interviewees(Crawford 2004)[54]. They point out that service users' perception of CC is better if they have the opportunity to build a long-term therapeutic relationship with one professional, if "contextualising" takes place (which means that professionals who have known the patient for a long time help other professionals to reframe the problems in the same way), and if key-workers are willing to adopt a flexible approach to care.

4.5.2 Services and systems integration

First, two USA-based large multi-centre studies will be discussed that specifically aimed to clarify the effect of services and systems integration on persons with SMI: the Robert Wood Johnson Foundation (RWJF) Program and the ACCESS program. One Dutch study evaluating the effect of care networks on service use is also mentioned.

Next, other reviews and studies evaluating "Shared care" will be discussed, since "shared care" as defined previously (see chapter 4.1.1.4) can be considered to be a certain way to realize "services and systems integration".

4.5.2.1 The Robert Wood Johnson Foundation (RWJF) Program (USA)

In the RWJF program, nine medium-to-large USA cities received subsidies to integrate care for individuals with chronic mental illness (CMI) through two levels of re-organization (Lehman 1994, Morrissey 1994, Durbin 2006, Adair 2003)[49, 52, 144, 145]. At the systems level, a local mental health authority (LMHA) was created to re-organize local provider agencies across a wide range of sectors (i.e., health, housing, social welfare and mental health) into a well-functioning network of coordinated services. LMHA had clinical, administrative and fiscal responsibility. At the services level, case management programs were implemented to provide CMI persons with individualized assistance to obtain needed services. One comparison city was included in the evaluations.

First, the performance of the LMHA was evaluated; all sites succeeded rather well in the creation of a LMHA and ratings of the network structure improved over time. Second, continuity of care (CC) was compared for 2 cohorts of SMI persons, and level of CC was compared with evolution in patient outcomes. Patients were included at discharge from the hospital. Cohort 1 (N=359): discharged during the early stages of the project. Cohort 2 (N=302): discharged later, after the LMHA was expected to have moved the system to a higher level of integration. Structured patient interviews at discharge and at 2 and 12 months after discharge asked about symptoms, functioning, quality of life and about received mental health services. Continuity indicators included having a case manager; changing case manager; having any service needs; amount of unmet need (i.e., needs addressed divided by needs identified); and perceived helpfulness of services. The expectation was that continuity of care and clinical outcomes would be better for cohort 2 than cohort 1 clients.

Improvements of CC from cohort 1 to cohort 2 were modest (at 12 months significant better result for cohort 2 for two CC indicators ($p<0.05$, ANCOVA) but not for the 3 other indicators). Patient outcomes at 2 and at 12 months were not different between the two cohorts for days of hospitalization, self-reported level of functioning, and life satisfaction, and clinical symptoms were worse in cohort 2.

It is concluded that the realized enhancement in service integration at a system levels does not clearly affect continuity of care at a patient level, and it does not affect patient outcomes in the domains of symptoms, functioning, and quality of life. Several criticisms have been formulated on this study, especially that evaluation parameters might have been too limited, that evaluation might have come too early to fully capture effects of the systems changes; and that the quality of the case management supply might have been suboptimal at some sites. Nevertheless, the "lesson for the future" was to attend to quality of care at the same time as systems change and/or services change: "case management alone is not sufficient". (Goldman H 1994)[58].

4.5.2.2 The ACCESS program (USA)

The ACCESS program (Access to community care and effective services and supports, USA, 1994-1998) evaluated if greater integration and coordination among agencies within service systems would improve outcomes among severely mentally ill (SMI) homeless people (Morrissey JP 2002)[146]. Nine intervention sites received additional technical support and funding to implement strategies of systems integration (e.g. integration coordinator position, interagency coordinating body, cross-training, client tracking systems); matched control sites did not receive this support. Over four years time, intervention sites implemented a higher number of integration strategies and achieved an increased integration among service agencies, as calculated based on the social network method[147].

The included SMI persons (N=7055) should not yet be involved in community treatment at baseline. The 18 involved intervention and control sites all received funding to implement ACT, which was offered to all participants entering the study. From baseline to follow-up, substantial improvement was observed in mental health (observed and self-reported signs or symptoms; number of psychiatric or service contacts) and substance abuse outcomes, in housing stability, in rate of employment, and in quality of life; but no statistical significant difference was noticed between experimental sites and control sites. More extensive implementation of systems integration strategies was also unrelated to these outcomes. However, sites that became more integrated, regardless of the degree of implementation or whether the sites were experimental or comparison sites, experienced progressively better housing outcomes. It can be concluded from this study that efforts to integrate systems lead to improvement at the systems organization level, but they lead to little or no improvement in the clinical outcomes and quality of life for severe mentally ill persons. One of the authors' assumptions to explain these results is that the presence of effective ACT services at experimental as well as control sites, might be responsible for the overall positive effects, and that ACT services create service integration from the bottom up[148].

Rothbard et al. (2004)[149] studied the long-term follow-up data of the ACCESS program. They compared for a limited number of participants (N=146) from one state the Medicaid administrative data one year before, during and one year after termination of the ACCESS study. In this study, no difference was made between experimental or control site, since the results of the ACCESS study showed no difference in outcome (Rosenheck 2002)[150]. It learned that one year after the ACCESS study, participants still had a significantly larger use of ambulatory care and a better continuity of care (outpatient contact within 30 days of inpatient discharge) as compared to the one-year period before their participation. The percentage of homeless persons with SMI in need of inpatient care or using emergency services was not different before, during and after the ACCESS program. Although there was no difference in the percentage of SMI persons in need of hospitalization pre-, during and post-intervention, hospitalizations became shorter during the interventions and tended to stay shorter afterwards but the difference was not statistically significant anymore. These results should be interpreted cautiously, since there is a potential selection bias (continuously Medicaid eligibility for 3 years; or less than 25% of ACCESS participants for that state).

In a further evaluation of the first 2 year data of the ACCESS study, Rosenheck et al (2001)[151] found a significant relationship between the social environment in the community and the degree of service system integration as measured in the ACCESS program. The community social environment was measured 1. by its "social capital" (defined by the results of the annual national lifestyle and social behavior survey, and by the % of people taking part in voting) and 2. by data on housing affordability. The higher the "social capital" of a community, the higher the level of service integration in the ACCESS study, and the higher the chance of exiting from homelessness for the ACCESS participants. This chance was also influenced by the housing affordability. Thus, according to these results the level of service systems integration seems to be influenced by the social context in a community, and this remains important even when additional efforts to implement integration strategies are provided.

The results from the ACCESS study confirm the results from a previous large USA study, the Robert Wood Johnson Foundation's program on Chronic Mental Illness (Lehman 1994)[144] (see before).

The previously mentioned RCT by McHugo et al (2004)[72], including 125 participants, confirm the results of the ACCESS study.

4.5.2.3 *Care networks and service use*

One Dutch study evaluated the effect of care networks on service use (Wierdsma 2007)[152]. Community care networks, consisting of a partnership between police force, housing corporations, social services, specialized home care and mental health services, were set up for chronic psychiatric patients in a few underprivileged neighbourhoods in Rotterdam but not in other neighbourhoods with comparable social profile. Over a 10-year period, contacts with psychiatric emergency services were higher in the neighbourhoods where community-care networks were set up, and number of admissions and standardised ratios for involuntary admissions were lower. The community-care networks had a significant impact on the use of mental healthcare services. The study did not describe individual patient outcomes.

4.5.2.4 *Shared care*

In this paragraph interventions in line with the definition of Shared care (see chapter 4.1.1.4) will be discussed. Only reviews or studies including SMI persons have been retained.

As will be noticed, some authors prefer the term "collaborative care" instead of "shared care" when discussing liaison services (e.g. Craven et al (2006) and Mitchell et al (2002)[43, 44]).

Finally, 2 studies will be presented that don't deal with "Shared care" as defined in 4.1.1.4, but in these publications a shared or *joined patient-doctor decision making* is one of the key elements of the intervention. The authors of the first study call this "collaborative care" (Bauer et al (2006); Simon et al (2006)[45, 46, 153]); the authors of the second publication call it "shared decision making" or "integrated care" (Malm 2003)[47].

A. Cochrane and CRD database

Cochrane Review by Smith et al (2007)[41]: "Effectiveness of shared care across the interface between primary and specialty care in chronic disease management."

This Cochrane review on chronic diseases includes studies based on the liaison model, based on shared-care record cards or IT-supported shared care, or based on combined interventions. Three studies on persons with chronic mental illness are included: Byng 2004 (RCT)[154], Wood 1994 (controlled before-after study)[155] and Warner 2000 (RCT)[156]. Byng evaluated the liaison model ("Mental Health Link") between primary care mental health teams and GPs practices (335 participants). Wood evaluated the liaison model between a specialist case management team and GPs practices (118 participants); and Warner evaluated patient-held shared care record cards (90 participants). All three studies had some methodological flaws. Byng in the UK reported a significant 32% difference in number of patients experiencing a relapse; Wood in New-Zealand found a significant decrease in number of patients that were re-admitted, and in the number of in-patient days. Warner in the UK found no difference in general mental health outcome. Quality of life and satisfaction with treatment were not different in Byng or Warner. The authors of the Cochrane review conclude that there is insufficient evidence to demonstrate overall significant benefits from shared care.

Cochrane Review by Gruen et al (2003)[157]: "Specialist outreach clinics in primary care and rural hospital settings".

This Cochrane review included one study reporting separately on SMI persons (psychosis): Williams 1989. It shows that, for the time period 1973-1981 as compared to before, the development in the UK of psychiatrist liaison services to general practices was accompanied by a nationwide reduction in admissions of non-psychotic disorders; however this was not true for psychotic disorders.

However, this type of observational studies does not necessarily imply a causal relationship, since many other factors might have contributed to the effect on patient admission.

Roberts L et al (2001)[158]: Systematic Review: "The effectiveness of health assessments in primary care as a strategy for improving both physical and mental health in patients with schizophrenic illness". West Midlands Health Technology Assessment Collaboration, Department of Public Health and Epidemiology, University of Birmingham (WMHTAC).

The available data are insufficient to determine the effectiveness of health assessment for schizophrenic patients in primary care. There is little evidence to suggest that undertaking health assessment of schizophrenic patients (outside of the usual health promotion activity of general practice) in primary care is an effective way of improving the mental or physical health of this patient group.

B. Medline, PsycInfo, Embase

Craven et al (2006)[43]: Systematic review: "Better practices in collaborative mental health care."

In this systematic review of low quality the term "collaborative care" largely corresponds to the definition of "shared care" used in this report. The review by Craven et al is also mentioned in McDonald et al (2007)[159]. Craven et al include 7 studies on persons with SMI: Warner 2000 (RCT, also included in the Cochrane review on shared care)[156], Lester 2003 (RCT)[160], Burns 1998 (RCT)[161], Gater 1997 (RCT)[162], Bindman 2001 (case-control)[163], Cook 2003 (before-after design)[164], Druss 2001 (RCT)[165]. Six studies were UK-based, one study USA-based (Druss 2001). The authors of the review assigned to each study a "level of collaborative care", which could be high, medium or low. The rationale of this rating was not explained.

Warner 2000 and Lester 2003 (203 patients) both report on patient-held clinical care records carried back and forth between providers. From these 2 studies it is concluded that this may have some positive effects on communication but that changes in clinical outcomes are unlikely.

A liaison model of service provision is evaluated in the studies of Gater 1997 (89 patients), Druss 2001 (120 patients) and Bindman 2001; in the Gater study each patient additionally has a care coordinator. Gater and Druss reported more guideline-consistent care, more patients had regular contacts with services and patients were more satisfied with care. Bindman found that admission rates to specialist care are not enhanced by the intervention.

The study of Burns 1998 examines the impact of teaching UK nurses to carry out structured patient assessments; but this study is excluded by Craven et al because of major flaws. The study of Cook 2003 has a mixed intervention (liaison, patient held record, ACT, accommodation and therapy supply, staff training), so that it is difficult to disentangle the element responsible for the results.

From this review it is clear that more studies in the field of SMI persons are necessary before firm conclusions can be drawn on the role of shared care.

Mitchell et al (2002)[44]: "Does primary medical practitioner involvement with a specialist team improve patient outcomes: a systematic review".

This SR of good quality includes 2 trials on persons with SMI: Wood et al (1995)[155] (also included in the Cochrane review by Smith et al (2007)) and Gater et al (1997)[162] (also included in the review by Craven et al (2006)) (see before).

The formal liaison between GPs and specialist services in outpatient care seems to have modest beneficial effects in chronically mentally ill patients, but results are only based on 2 controlled trials of 118 and 89 patients respectively.

Fitzpatrick et al (2004)[166]

This prospective observational study describes data from 349 SMI persons from 50 GP practices in London who were followed during one year. Level of shared care (SC) was scored by the GP on the SCAS (Shared care assessment schedule); low, medium and high level of SC was defined on the tertiles of all patient scores. High SC represents active involvement of primary and secondary services with good communication, low SC represents patient management almost entirely by general practitioner (GP) or within secondary care. At 12 months, there was no difference between participants receiving different levels of shared care for number of hospital admissions or length of stay. Also, there was no difference between participants receiving different levels of shared care for change in global clinical symptoms, social functioning or satisfaction with services. The authors conclude that high shared care had limited value for patients in terms of improved clinical, social or general health functioning over 1 year. However, there may be other drivers for implementation of shared care, e.g. managing risk or supporting professionals.

Kisely et al (2006)[167] conducted in Canada a survey among 37 primary care physicians with access to mental health workers, e.g. psychiatrists, psychologists, social workers, nurses, who provided on-site clinics in mental health care. They were compared to 64 primary care physicians without such access. The methodology of this survey-based study is weak, but the results are mentioned because of the qualitative information. Results should be treated cautiously. The first group reported significantly better knowledge in some areas of diagnosis and therapy of mental health problems (e.g. psychosis). They also reported more comfort in managing these problems, and were more satisfied with mental health services, over and above shared care.

Shared or joined patient-doctor decision making as a key element of the intervention

Two studies (Bauer 2006, Malm 3003) don't deal with "Shared care" as defined in 4.1.1.4, but a *shared or joined patient-doctor decision making* is one of the key elements of the intervention. As discussed below, the interventions in these studies are complex and multi-faceted, so it is difficult to conclude on the precise role of the "joined decision-making" in the results.

Bauer et al (2006)[45, 46] and Simon et al (2006)[153] evaluate a model that they describe as the "Collaborative care model". It includes 1. joint (patient-doctor) problem definition, goal-setting and planning 2. group psycho-education (4-6 persons) on self-management skills (Life Goals Program) 3. simplified practice guidelines to support clinician decision 4. nurse care coordinators. The model is evaluated for severely ill patients, in a multi-center RCT and involving 330 patients with bipolar disorder and many co-morbidities (Bauer 2006), respectively 441 patients with bipolar disorder but less co-morbidities (Simon 2006). At three (Bauer) respectively two (Simon) years, the frequency and severity of mania in bipolar disorder was significantly reduced by the systematic care-program. The effect on the depressive episodes was less clear. There was no difference in psychiatric hospitalization rate or medication use between groups. The effect on social functioning and QoL was not clear.

Malm et al (2003)[47] conducted an RCT and included 84 SMI persons with schizophrenia. SMI persons involved in shared decision making carried out in social network resource groups, including training in problem solving and communication, do significantly better at 2 years follow-up for social functioning and satisfaction with treatment, but not for clinical functioning.

4.5.2.5 Systems and services integration: conclusion

Does systems integration affect continuity of mental health care and patient outcomes? The RWJ study and the ACCESS study learn that efforts to integrate systems lead to some improvement at the system's organization level. Their effect on continuity of mental health care for SMI persons is not clear and at best limited. However, they lead to little or no improvement in the clinical outcomes and quality of life for severe mentally ill persons.

Many methodological limitations can be formulated in relation with these studies. On the other hand, it is probably difficult to improve study quality for this type of very large and complex interventions.

To the most fundamental criticisms belong the following:

- in the RWJF study as well as the ACCESS study selection bias cannot be excluded (see above), which further compromises the study outcomes;
- study duration was not long enough to capture real changes, especially at a systems level (although the follow-up duration for the ACCESS study was four years);
- indicators of continuity of care were too narrow and some important aspects were not captured; after these studies some more sophisticated instruments to measure CC became available (e.g. the ACSS-MH or Alberta continuity of service scale for mental health)
- evaluation of patient outcomes, especially patient satisfaction with services, was too limited to capture changes;
- the relationship between service systems integration, continuity of care at a patient level, and patient outcomes is very complex and is determined by many other factors. This makes it very difficult to measure a direct relationship between patient outcomes and service systems integration or continuity of care.

Shared care as defined in this report can be considered to be a specific subtype of systems and services integration. It addresses specifically the boundary between primary care and specialist care. It has most been studied as the liaison model: in a meeting between specialists and primary care professionals clinical problems are discussed, and often this is supplemented by a clinic run by specialists in a primary care setting. Results so far are not consistent in terms of improved clinical, social or general health functioning of the patient, or patient satisfaction with care. However, there may be other drivers for implementation of shared care, e.g. managing risk behavior by patients or supporting professionals. Another form of shared care is the use of shared care record cards to facilitate communication between professionals; these cards are usually carried by the patient. There is no evidence that it improves mental health status of SMI persons or their satisfaction with care; especially patients with psychotic illnesses are less likely to use the cards.

Given the enormous efforts (man-power as well as subsidies and funding) that are necessary to implement systems integration for (severely) mentally ill persons, and given the limited evidence that this improves patient outcomes, caution is warranted not to overstate the importance of systems integration and services continuity of care. One should not forget that many other aspects, among which the intrinsic quality of the provided services, are at least as important: "ineffective services are not improved by better integration" (Goldman 1994)[58]

4.5.3 Care programs, Care pathways

A. Cochrane and CRD database

No references retrieved

B. Medline, PsycInfo, Embase

"Care programs" and "Care pathways" in mental health care clearly belong to the focus of the main questions for this report formulated by the Belgian Government. A specific search (summer 2007; repeated in June Nov 2009 because of the importance for the report) followed by selection through the main in- and exclusion criteria, did not yield results for "Care programs". For "Care pathways" in mental health care, Evans-Lacko et al (2008)[63] provide an overview of all research published so far. Eight studies were included, six of these concerning SMI persons. However, several studies did not specify clear outcome criteria. One study included a control group but conclusions from this study are difficult to make because of a low completion rate. Overall, the study results were mixed and due to the low overall quality, no conclusions can be made. Importantly, most of the studies cited the importance of contextual factors in the development of the care pathways.

5 LITERATURE REVIEW: CONCLUSIONS

5.1 DIAGNOSIS OF "CHRONIC AND COMPLEX" OR "SEVERE AND PERSISTENT" MENTAL ILLNESS.

In 2005, the federal Minister of social affairs and public health commissioned the "Therapeutic Projects", meant to try out new initiatives to create care circuits and care networks for "persons with a chronic and complex mental disorder". The present report can be seen in the broader perspective of a reflection on the organization of care for this patient group. Indeed, in Belgium a specific subgroup of mentally disordered persons is considered to be suffering from a chronic and complex disorder, and this term is widely used although no specific scientific definition exists. More precisely, "chronic" relates to duration and persistence of the disorder. "Complex" rather refers to the fact that these persons have needs that cannot easily be solved by one single professional discipline because many dimensions, including functioning in daily life and participation to society, are involved. .

In the contemporary scientific literature, most authors prefer the expression "persistent" to the word "chronic", which is felt to have a negative connotation; and the complexity of the included disorders is expressed by "severe". Since the principal aim of this study is to give an overview of existing scientific evidence, the term "severe and persistent" mental illness has been used, rather than the term "chronic and complex".

5.1.1 Definition of "severe and persistent" mental disorders

According to the scientific literature, the definition of "severe and persistent" mentally ill patients (SMI patients) includes 3 components: diagnosis, duration of illness, and severity of illness (or degree of functional impairment) along the spectrum of a certain diagnosis (see chapter 2).

Although for all included publications in the literature review of this study the 3 components (diagnosis, duration and severity) were looked for, in the majority of papers only the diagnosis was mentioned.

To make it even more complicated, diagnostic categories varied from one to another paper. Two diagnoses were often but not always included when considering "chronic" or "severe and persistent" mental illness. The most important is schizophrenia and other forms of non-organic psychosis, usually accounting for more than half of the described patient population, and sometimes the only included diagnostic category. The second most important diagnosis is major affective disorder, i.e. bipolar disorder and sometimes also major depression. It is confirmed in the literature that these two diagnostic categories are the 2 most important SMI diagnoses (Bhugra 2006)[168]. Personality disorders, often without any specification, are sometimes also taken into consideration but they usually account only for a small subgroup of all included study participants; some papers deal with this diagnosis separately. Substance abuse and addiction are mostly only included in SMI studies when they are secondary to another "chronic" or "severe and persistent" disorder; as primary diagnosis they are usually excluded. The problem of offenders and forensic psychiatry, is mostly considered as a specific subcategory of "severe and persistent" psychiatric care and is dealt with in separate papers.

Adding to the problem of which diagnostic categories to include, is the well-known fact of the cultural influence on psychiatric diagnoses (Bhugra 2006)[168]. For instance, Jablensky et at (1992)[169] showed that the rates of narrow definition schizophrenia were broadly similar across nations, but broader definition schizophrenia varied nearly twofold.

A further problem is that in those papers including "duration" in the diagnostic criteria of SMI, different cut-offs are used, varying from 6 months to 2, 3 or even 5 years (see KCE-report n° 84). When the criterion of severity is included, different outcome scales are used to measure it, making comparability from one study to another difficult.

In conclusion, the necessity of 3 components for the scientific definition of SMI so far still remains largely theoretical. In the majority of the published scientific papers inclusion criteria for the group of severe and persistent mentally disordered patients are limited to the medical diagnosis and the duration of the disorder. So far the available scientific evidence as to the disability-concept remains limited. No uniform operational definition yet exists for "severe and persistent mental illness", and variation is possible from one study to another.

Notwithstanding its vagueness due to the lack of well-defined in- and exclusion criteria, the concept of SMI is generally accepted and often used in the literature. The Cochrane reviews, to give only one example, solve the problem by using as an inclusion criterion "severe and/or persistent, however diagnosed".

In the Belgian context of care organization for this group of patients, the concept of "chronic and complex" or "severe and persistent" is in practice often defined based on the patient's diagnosis combined with a minimal duration of six months of illness. However, if one aims at developing a framework for organization of (chronic) care for these persons, it should be repeated once more that the WHO and other influential institutions state that the actual needs of the persons suffering from SMI should be the starting point for every therapeutic and social care-giving act. Notwithstanding the fact that in practice most of the patients of the SMI group will belong to only a few diagnostic categories, their needs might be different depending on their living situation: a chronic schizophrenic person living in an institution has different needs compared to the same person living independently in society.

5.1.2 Prevalence of severe and persistent mental disorders

It was not the purpose of this report to give an exhaustive overview of the literature on prevalence of severe and persistent mental disorders. Nevertheless it seems useful to give a global impression of the number of affected persons, starting from the 3 most frequently included diagnoses (see 5.1.1)

According to recent overviews, schizophrenia has a life-time prevalence (proportion of individuals alive on a given day who have ever manifested a disorder) of 0,4% and an annual prevalence of about 0.3% (proportion of individuals who manifest the disorder during a time period of 1 year) (Saha 2005)[170]. For bipolar disorder (Ketter 2010, Ormel 2008)[171, 172], the life-time prevalence is 4% and the annual prevalence 1,4%. For major depressive disorder, the life-time prevalence varies from 6-18% and the annual prevalence from 4-6% (Patten 2008)[173]. However, as discussed by Patten, a certain proportion of major depressive disorders will recur, but not every person suffering a major depressive disorder will finally respond to the diagnostic criteria for SMI. In the WHO survey ESEMeD (2001-2002), the annual prevalence of "serious mental disorders" in Belgium was 4,9%. "Serious mental disorders" were defined as severe and persistent mental disorders (SMI persons) plus either a 12-month suicide attempt, an impulse control disorder with repeated serious violence, or any other mental disorder that resulted in 30 or more days in which the respondent could not carry out daily activities as usual (Bruffaerts 2009)[174].

In conclusion, severe and persistent mental disorders are not rare, and an annual prevalence lower limit of about 1% seems a realistic estimation.

5.2 LITERATURE EVIDENCE ON ORGANIZATION OF MENTAL HEALTH CARE

5.2.1 Methodological reflections

It is difficult to evaluate interventions aimed at producing change in the organisation and delivery of health care services, because they are usually very complex. Complex interventions are defined by the UK Medical Research Council as those comprising "a number of separate elements which seem essential to the proper functioning of the interventions although the 'active ingredient' of the intervention that is effective is difficult to specify". (Shepperd 2009)[175]. Typical examples of such complex interventions are case management, interventions to improve continuity of care etc.

Shepperd et al (2009)[175] underline the methodological issues arising from the synthesis of data from complex interventions. Important difficulties, and possible solutions proposed by these authors, are:

(1) defining the intervention within the review; solutions can be using a typology for classification; contacting authors for precise information on interventions, using supplementary evidence e.g. including a broader range of study designs or qualitative data to describe the active ingredients of the intervention;

(2) searching for and locating (all) relevant evidence; solutions can be performing an iterative scoping exercise, retrieving references of references, searching outside traditional health care domains;

(3) standardizing the selection of studies for a review; solutions can be refining the definition of the intervention of interest through an iterative process when assessing how similar another intervention is; being explicit in the review on difficulties in classifying certain studies;

(4) synthesizing data; a solution can be synthesizing heterogeneous data by means of a narrative review, paying attention to intervention content (specifying active ingredients and contextual similarities/differences between trials), to intervention fidelity and sustainability (did the intervention fail because it was poorly implemented), and to the applicability of the evidence in other health systems.

The subject of the literature review in this report typically belongs to the domain of the "complex interventions", and indeed, many methodological difficulties might hamper the results.

(1) To standardize as much as possible the "intervention" in this review, the organization of mental health care, and to stratify the diversity of mental health services, a "typology" has been used: the ESMS. This taxonomy for classification of mental health services has a glossary describing its subdivisions and has been validated for use in several countries; and although not perfect, it was judged to be the most relevant given the scope of this study (see chapter 2).

A rather broad selection of study designs has been included (meta-analyses, (systematic) reviews, RCTs and clinical trials, cohort studies, case-control studies). Whereas this strategy certainly widened the variety of organizational concepts that have been included, results should be interpreted with caution. On the other hand, qualitative data has only been picked up when retrieved through the general search strategy and no specific search on qualitative data has been performed. For pragmatic reasons, the search in this report has been limited to non-sociological databases.

(2), (3) To address the lack of consistent terminology and the inconsistent use of existing terminology to describe mental health care organizational interventions, the ESMS has guided the literature search strategy (see Appendix to chapter 3). On the other hand, the scope of this taxonomy is to give an inventory of mental health services, and not of the content of the delivered interventions delivered, nor of the combination of certain types of interventions.

However, to validate the search outcome and to include the most important subjects that might have been omitted in the first search, an independent researcher conducted a second search (see Appendix to chapter 3). These search results were matched with the first search strategy.

In this review, a broad search strategy has been used (see Appendix to chapter 3), and iterative exercises and scrutinizing of reference lists have been performed. However, due to the inconsistent use of existing terminology it is possible that potentially eligible studies have not been identified or have been discarded early in the review process. Moreover, on many service components belonging to the arsenal of most West European countries, e.g. day centres for SMI persons, no publications were found; so it is not possible to conclude on their efficacy as compared to other services.

(4) As can be concluded from the evidence tables in the Appendix to chapter 4, the heterogeneity between the included studies is large, not only for the included SMI population (e.g. only psychoses or not) but also for the evaluated outcome domains (clinical symptoms, quality of life...) and the outcome scales used. Throughout the literature, a similar term is used for services that not necessarily provide the same, and the comparator "usual care" is often ill defined. Moreover, as already pointed out in chapter 2, due to their social characteristics service interventions are never alike; and an intervention never gets implemented identically because of differences in context, timing, processes, stakeholders etc. Many of the studies included in this literature review were conducted in the USA or UK, and caution is warranted when transferring the results to the Belgian context.

Taking all these methodological limitations in consideration, and taking into account the potentially important influence of contextual factors, the retrieved evidence mostly was of low or at very best of moderate quality (Gyatt).

However, given the complexity of organizational interventions, it is not unlikely that even the best review will always leave much more uncertainty than for instance reviews dealing with the efficacy of drugs. Organizational interventions are always inevitably contextually embedded; hence the notion of intervention cannot automatically be considered as a standardized set of elements.

5.2.2 Which mental health care services to organize for SMI persons?

Western Europe has witnessed a now well-established trend of deinstitutionalization for persons with SMI, and a tendency towards community-based services. This deinstitutionalization was started as a social movement characterized by the choice to overcome stigma and integrate people with mental disorders into society, without evidence being available for its feasibility or effectiveness. Since then, no persuasive arguments came available to support a hospital-only approach. Evidence exists that community care, including home-based care, is an acceptable way of treating people with SMI, and is associated with more service satisfaction and quality of life (see chapter 4). Likewise, there is no scientific evidence that community services alone can provide satisfactory comprehensive care. Instead, **the weight of professional opinion and results from available studies support "balanced care", incorporating elements of both hospital and community care.** This concept has been first described by Thornicroft et al.(Thornicroft 2004)[176] and also by Knapp et al (2007)[18], and by Vieth et al (2009)[177]; it implies that community-based and hospital-based services commonly and in a coordinated way aim to provide treatment and care that are close to home, including acute-hospital care and long-term residential facilities in the community. Both community-based and hospital-based services should respond to disabilities as well as to symptoms, they should be able to offer treatment and care specific to the diagnosis and needs of each individual, they should be related to the priorities of service users themselves and respect international conventions on human rights.

This "balanced care" model should be a "pragmatic" balance between hospital care and community-based services, which means that no fixed number of beds or community places can be put forward. These numbers are highly dependent upon what other services exist locally and upon local social and cultural characteristics (Thornicroft 2004)[176].

The model is also presented as a "stepped care" model, which implies that, depending on the needs of the patient, first level care should be offered first, and second or third level only when necessary.

The first level of this model implies primary care with specialist back-up. The second or mainstream specialist level consists of outpatient and ambulatory clinics, community mental health teams, acute in-patient care, long-term community based residential care, and services in charge of employment and occupation. The third level or highly specialized (differentiated) mental health services are optional, but it is supposed that high resource level countries such as Belgium, are able to offer some of them, depending on the local context of service provision. A few examples are specialist clinics e.g. for eating disorders, home treatment and crisis resolution teams, facilities for independent living.

A few **additional remarks pointing to specific domains in the large field of mental health care organization,** can complete the knowledge on which mental health services to provide. It should be kept in mind that many of the included studies were performed in the USA or the UK, so extrapolation toward other countries should be done with caution.

- For homeless SMI persons, providing permanent housing and support can significantly reduce homelessness, hospitalizations and imprisonment (moderate quality of evidence). It does not influence clinical symptoms, social outcome or quality of life as compared to standard treatment. Providing "housing services" and "support services" in an integrated way is more effective as compared to non-integrated service provision. Results are comparable to the effect of ACT (see further) on housing stability; for this group of SMI persons ACT has additional advantages on clinical symptoms.
- Home care crisis treatment, provided within other ongoing home care services, is an acceptable way of treating SMI persons, with comparable clinical outcomes and better acceptance by both patients and family as compared to acute in-patient care (moderate quality of evidence). However, it is estimated that about half of these patients are unable to avoid hospital admission at a certain point during follow-up.
- For persons in acute distress (all diagnoses), acute day hospital treatment is a valuable alternative to acute in-patient care, with comparable results for clinical and social outcome, quality of life and satisfaction with treatment (moderate quality of evidence). However, it is not a valid option for every-one and it is estimated that it is feasible for 1/5 to 1/3 of those currently admitted to inpatient care.
- There is insufficient evidence to determine whether day hospitals providing day treatment programs (more intense treatment for patients who failed to respond to outpatient care) or transitional day hospitals (time-limited care for patients who have just been discharged from hospital) have advantages over outpatient care for SMI persons.
- Community mental health teams are not inferior to hospital based care or non-team outpatient care for SMI persons, and they are superior in promoting greater acceptance of treatment. They probably reduce hospital admission during follow-up, but further research is necessary (low quality of evidence).

- Home-based continuing treatment for mental disorders including SMI persons, can reduce the number of days spent in hospital during follow-up, when compared to hospital based care. The difference between home-based care and other forms of outpatient care is less clear. Evidence for this conclusion is of moderate quality. However, attention should be paid as to the sustainability of these services since many of them have disappeared after some years.
- It is not possible to decide on the efficacy of non-hospital-based day-centers that offer structured activities for patients with long-term severe mental disorders, since no studies based on good methodological principles were retrieved.
- There is moderate quality of evidence that supported employment models, which emphasize rapid placement in competitive jobs with "on-the-spot" support and follow-up from professionals, are more effective than vocational rehabilitation, and can increase rates of competitive employment.
- There is moderate quality of evidence that case management (a case manager provides coordination for health and social care needs for SMI persons residing in the community. He typically works more individually than ACT managers who work in team, and has a higher case-load. He refers clients to care providers rather than providing care necessary interventions by himself) can ensure that more people remain in contact with psychiatric services (one extra person remains in contact for every 15 people who receive case management). However, it increases hospital admission rates (moderate quality of evidence). Effects on clinical symptoms or the patient's level of social functioning are not clear.
- ACT (assertive community treatment: a multidisciplinary team that coordinates the care of SMI persons in the community, preferably at the patient's own home or work place. The team attempts to provide necessary interventions by themselves rather than referring patients to other providers): evidence exists that ACT can decrease hospitalization, decrease the number of SMI persons lost to follow-up and increase the number of SMI persons living independently, being employed and being satisfied with their services. Effects on clinical outcomes or social functioning are less clear. Some recent studies in a European context failed to find the same positive outcomes on hospital use. It seems that the effect of ACT on the rate of hospital admissions is most pronounced when hospital use is intense; in other words, if hospital use is already low, ACT is not likely to reduce it further.
- For people with dual diagnosis (co-occurring mental disorder and substance abuse), the existing evidence does not support integrated treatment of both disorders, but further research is still necessary.
- Due to a lack of consistent publications, it is currently not possible yet to judge whether specialized early intervention teams (e.g. early psychosis teams) should be seen as a priority.

5.2.3 Integrated care, Continuity of care, Care pathways and Networks of care for SMI persons: the evidence.

5.2.3.1 The concepts "integrated care" and "continuity of care"

During the last few decades, the concepts "integrated care", "service integration" and "continuity of care" have been used broadly in the field of service organisation for people with complex needs. Throughout the Western world, these concepts are also widely considered to be important elements of contemporary care for mentally disordered persons, especially for those with severe and persistent mental disorders. This vision implicates the assumption that non-integrated, discontinuous service delivery systems are less able to address the needs of these people.

The goals of integration are to provide comprehensive services; to improve access to these services; to improve continuity of care; and to reduce service duplication, inefficiency and costs (Randolph 1997)[48]. Ultimately, this should lead to an improved clinical status and better quality of life for the person with mental illness (Durbin 2006)[49].

So far, no uniformly accepted definition of "Integrated care" (IC) or "Continuity of care" (CC) exists is in the literature on mental health care, but it is clear that they are complex concepts with many different aspects (see chapter 4.1). It is beyond the scope of this report, to give a comprehensive theoretical background on these concepts. Rather a practical overview is given of the interpretations found while evaluating the literature on mental health care organization; these descriptions have been used also elsewhere in this report.

Integrated care

According to several authors (Randolph 1997, Durbin 2006)[48, 49], when using the concept of IC, its content should be clarified as to the following aspects:

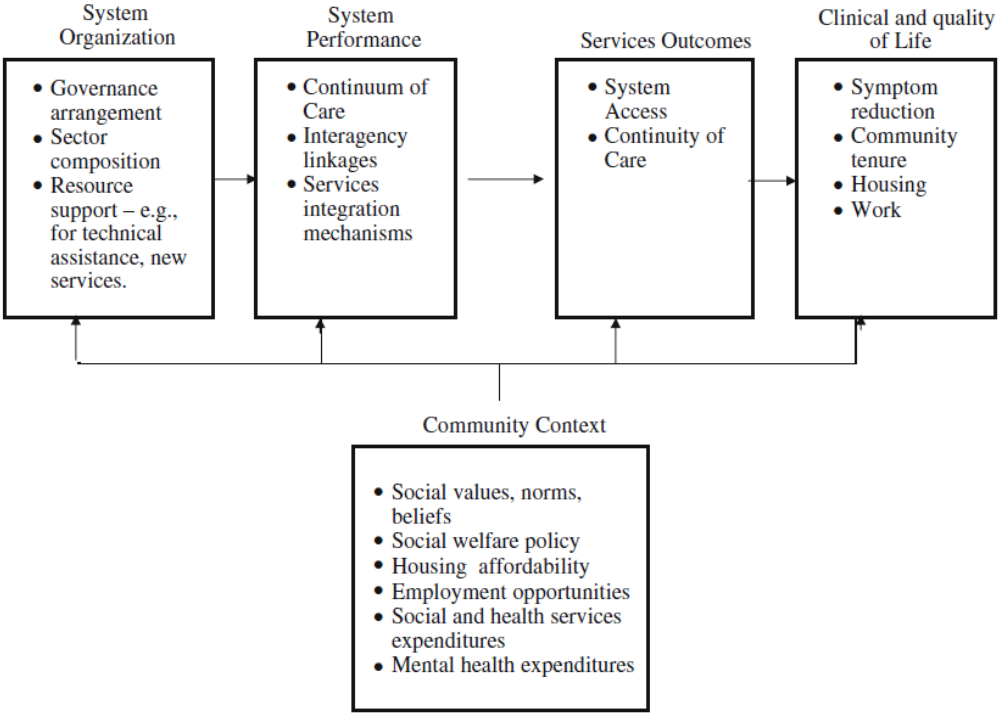
A. The *service system level* toward which activities are directed. This can be the "patient level" (for individual patients e.g. integration by case management), or the "service systems" level (for a defined population as a whole, e.g. program integration, integration at the state-level etc.).

B. The *intensity* of IC (a continuum ranging from loosely organised alliances to highly integrated organizations); and the formality of IC *governance* (a continuum from informal verbal agreements to formal procedures and rules).

In practice, the same authors often encounter the following five levels of increasing integration: information sharing and communication, cooperation and coordination, collaboration, consolidation, and full integration (see also 4.1.1.5).

To understand how IC and CC potentially can affect patient outcome, and how they relate one to another, Durbin et al (2006)[49] developed the "Systems integration logic model" (see Fig), a model describing 3 steps in this interaction process. Brief, a certain *care system* has a certain level of *system performance* (including the use of certain integration mechanisms), leading to the *services outcomes* (among which continuity of care); these service outcomes potentially influence *clinical symptoms and quality of life* of the patient. According to Durbin et al these steps are all influenced by the context of the community: e.g. in a community context of a high level of unemployment, less results can be expected from efforts to integrate vocational rehabilitation into the general service supply for SMI. For more details, see 4.1.1.5.

Fig: the Systems integration logic model (Durbin 2006)[49]



Continuity of care

When discussing "Continuity of care" in mental health services, reviews usually go back to the definition of Bachrach in 1981[50], who defined CC as "the orderly uninterrupted movement of clients among the diverse elements of the service delivery system". In the next phase, it becomes almost impossible to distinguish CC from interventions such as case management or ACT, since these interventions were basically developed to improve the continuity of care (Adair 2003)[52].

A next landmark is the "state of the science" given by Johnson et al (1997)[53], on "continuity of care" for severely mentally ill persons. Johnson distinguishes the following aspects of CC for SMI persons:

1. Cross-sectional:
   - receipt of a comprehensive range of services in accordance with needs:
     - continuity between service providers (degree of communication between agencies and professionals involved in the patient's care),
     - comprehensiveness (the range of services provided to meet the patient's needs),
     - accessibility of services (distance to facilities).
2. Longitudinal:
   - sustained contact with services and providers over time:
     - continuity of contact (provision of out-reaching care to stay in contact with patients),
     - continuity of service provider (patients receive services across time from the same staff),
     - implementation of service plans,
     - continuity through discharges and transfers (flexible and rapid transfer between care levels according to varying needs of patients).

To these aspects, Crawford et al (2004)[54] add still another important dimension: patients' views of the care they receive ("do they experience care as smooth and uninterrupted").

Whereas in the literature on mental illness still other definitions on CC are sometimes used by other authors, they usually come back to the factors mentioned above (see also chapter 4.1).

Given the diversity of possible interpretations of the concept IC or CC, it is of utmost importance to elucidate the concept whenever referring to it, and to define which aspects are included. Not giving a clear description of which aspects are aimed at, will almost certainly lead to confusion or misunderstanding, given this complexity.

Care programs and Networks of care

Other concepts often used in the context of mental health care organization, are "Care programs or care pathways" (CP) and "Networks of care".

CP is defined in this report as a proposed sequence of steps for clinical care for a particular group of patients.

A "network of care" can be defined as a collection of services which may vary in their activities or organization, but which share a common mission, operate in a more or less planned and collaborative manner, and participate in an overall coordinating or planning body or authority to which each has a degree of accountability (Kates et al 1993)[59]. In a theoretical background to networks, Goodwin (2004)[60] includes the dimensions "pattern of ties or links" and "accountability"; Perry (2006) defines networks on 2 continuums (social regulation and social integration); each network can be characterized by a certain degree of social regulation (hierarchy, accountability) and a certain degree of social integration (strength of binds between individuals belonging to the network)(Van den Holen 2008)[61].

According to ANAES (2004)[P], care networks aim to improve access to care, to improve care coordination, and to facilitate inter-disciplinary care for a subgroup of patients, disorders or services; care networks provide individually tailored care including diagnosis and treatment as well as prevention and patient education. Besides quality improvement, cost-effectiveness has also been mentioned as a potential advantage of care networks (Van den Holen 2008)[61].

In Belgium, the French term "trajets de soins" and the Dutch "zorgpaden" are the proposed translations for "care pathways". Nevertheless, it is interesting to note that among experts that collaborated on this report, the impression exists that the actual content of this term is differently interpreted in the French and the Dutch part of the country. This again emphasizes the need to clarify these concepts whenever they are used in a clinical and/or an organizational context, to avoid misunderstandings.

5.2.3.2 The literature evidence on "integrated care", "continuity of care", "care networks" and "care pathways" for SMI persons

Integrated care and continuity of care at the patient level

Some types of community care described above, actually include care integration and care coordination on the patient level: case management, ACT, integrated care for dual diagnoses (see 5.2.2)

Integrated care and continuity of care at the systems level

When evaluating the scientific literature on IC and CC for SMI persons, few but nevertheless important publications were found, all using different definitions and/or measures for "Service integration" or CC, which makes direct comparison difficult.

Nevertheless, they all pointed in the same direction:

Due to the many methodological difficulties discussed before, the quality of the evidence is low. On the other hand, it is probably difficult to improve study quality for this type of very large and complex interventions.

P www.anaes.fr

-Efforts to integrate systems lead to improvement at the systems organization level, but they do not clearly affect continuity of care at a patient level, and they lead to little or no improvement in the clinical outcomes and quality of life for severe mentally ill persons. An exception is improved housing stability for homeless persons with SMI, if housing services are integrated in the global service package for these people.

-Likewise, measures of CC can be useful in evaluating changes in the process of care, but CC is not straightforwardly related to individual outcome. So far, it has not been proven that CC by itself or in interaction with other features of service delivery ultimately improves well-being of SMI persons as defined by symptom control, functioning or quality of life.

One specific subtype of systems or services integration is Shared care, addressing the boundary between primary and specialist care. Best known is the liaison model of care, for which results in terms of improved clinical, social or general health functioning are so far inconsistent, as well as outcomes in the domain of patient satisfaction with care.

The scientific literature search yielded one more publication specifically addressing Care networks for SMI persons; no patient outcomes were mentioned and more evidence is necessary before firm conclusions can be made. For Care pathways, one review was found in which no conclusions could be made on the merits of this concept due to the scarce and inhomogeneous research available. In the 2nd part of this report ("International overview") some additional information on Care networks will be given

In conclusion, given the limited evidence that IC and CC at the systems level improve outcomes of SMI persons, and given the enormous efforts (man-power as well as financials) that are necessary to implement it, caution is warranted not to overstate the importance of IC and CC. Many other aspects, among which the intrinsic quality of the provided services, are at least as important: "ineffective services are not improved by better integration" (Goldman 1994)[58].

5.3 LIMITATIONS OF THE LITERATURE REVIEW

The methodological limitations typical of an EBM literature review and typical of complex interventions have already been discussed before (see 2.4 and 5.1). Some other limitations should also be considered.

Search strategy

- a broad search strategy with a minimum of specific terms has been deliberately used. Notwithstanding these efforts, it is not unlikely that publications have been missed, which is almost inevitable given the wide scope of this report.

Inclusion criteria

-considerable sociological research exists on the general theme of inter-organizational relations and networks of services, which has not been included in this report.

-in line with the international definitions, primary addiction problems were not considered to belong to the group of SMI persons. However, this implies already a bias and it prohibits looking objectively to the existing organizational structures in which often addiction problems are considered to be a separate group. The same holds true for forensic psychiatry and issues involving jurisdiction, as well as for psychiatric disorders in persons with intellectual disabilities.

-the theme of stigmatization has not been included, although a broad set of outcome parameters have been systematically looked for, such as medical and functional outcomes, aspects of daily living, quality of life or satisfaction with services, burden of carers. Stigmatization is an important theme though, and not only from the point of view of the person himself. Stigmatization potentially affects choices made by SMI persons which are reflected in organizational aspects.

-interventions aiming at family involvement were excluded, since they were considered to be a certain type of "face-to-face treatment". Nevertheless, such interventions require specific organizational concepts, which would have been worthwhile mentioning.

Research context

-as already emphasized at several points in the overview of the literature results, a lot of research in this domain has been conducted in the USA and the UK. The basic organizational and financing structures of mental health care and welfare in these countries are quite different as compared to Belgium. One should be very careful before introducing exactly the same concepts in our country; and when it comes to implementation an in-depth evaluation of the organizational and financing context of the concept should be made to avoid problems.

Research topics

-the empirical research that has been included was mainly based on experimental research designs while there appears to be a lack of research using naturalistic designs or focusing on real-life effectiveness. This remains a limitation of this report.

-mental health services research focusing on effects of social structure and organizational culture or on inter-organizational relations and networks has been poorly developed.

-especially the research on welfare services for SMI persons or on (non-hospital) alternative accommodation modalities is poorly developed, although these are very important themes given the de-institutionalization movement.

-evidence can also be generated by experiments "on-the-field", such as the Belgian "Therapeutic projects" and the "Therapeutic experiments". The interested reader is referred to the KCE-reports 103 and 123, which deal with this subject.

-it is obvious that if well-conducted research for a certain type of care provision is absent, one should not conclude that it is not evidence–based. It is very well possible that such a type of care provision has a valuable contribution to the mental health care supply - it only awaits a careful evaluation.

6 INTRODUCTION INTERNATIONAL OVERVIEW

6.1 SCOPE OF THIS SECTION

This section describes the organisation of mental health care in a selected sample of countries. It is descriptive and explorative, and does not aim to develop evidence on "one best way" to organise mental health care, as health service delivery models are profoundly affected by local conditions, historical developments and sociological, political and economic characteristics of a country.

This global international overview aims at synthesising the general rationales for organising mental health care services in other countries. The descriptive comparison enables to deduct some common and diverging developments that could offer relevant background knowledge to organise mental services, in this particular case in Belgium.

6.2 SELECTION OF THE COUNTRIES

We selected a sample of countries with a different history in health care organization, (mental) health care reforms, as well as diverging welfare regime backgrounds. The selection was based on a scan of available literature, contacts with key persons knowing the reforms in the sector, a meeting with Belgian experts, and the advise of an international expert.

1. Spain was chosen as an example of a geographically large southern European country. Since the mid 1980's it evolves as a Beveridge type model of health care organisation. It is characterised by regional health care governance, with its particular problems of regional divergences in the deployment of (mental) health care services.
2. France has a Bismarck type of health care organisation and is chosen for its long tradition of more hospital oriented care. Historically it was decided to have a hospital in each department. The mental health care policy has been characterized for its "sectorization" from 1975, in which the notion of catchment areas was considered as an important starting point. The issue of collaboration between the "cure" (medical) and "care" (social welfare) sectors for mental health care organisation is at stake.
3. The most recent policy changes in health care organisation in the Netherlands aim at developing a more demand/need oriented model allowing for personal choices in the selection of services. The Netherlands have a history of implementing community based mental health services, with a particular focus on developing networks of care.
4. Denmark is characterised by a long tradition and focus on decentralised community health care provision. The country has been subject to rather fundamental reforms mainly dealing with the relation between country, region, county and local communities. It has a quite particular approach in handling the collaboration of medical and non-medical aspects of mental health care
5. The UK has a Beveridge type of national health insurance system, going through movements of "market oriented" changes. It is characterised by decentralization of political health care responsibilities to each of the "countries". We mainly focused on developments in England. Recently "trusts" got the responsibility to provide in health services. England is chosen for its policy of gradually closing large asylums, and its efforts to develop integrated community care. It was also chosen because of its experience with scientific follow-up of mental health reforms (e.g. the TAPS project doing a follow up of patients after closing down mental hospitals)

6. Australia was chosen for its internationally recognized efforts to reform in a systematic way the mental health cure and care system and to introduce innovative practices.

To make a comparison easier, we will start with a description of Belgium along the same descriptive scheme.

6.3 GENERAL METHODOLOGY

In a first step, peer reviewed publications were searched in Medline, PsycInfo, Embase. However, due to the scarcity of relevant information on organizational models in this type of literature, this part of the report often relies on a grey literature search for public information from administrative authorities, non-indexed reports from scientific organizations, etc. Informal and personal communications with contact persons (research institutes, administrators) from the countries studied also contributed to this part of the report.

7 BELGIUM

7.1 LITERATURE SEARCH: METHODOLOGY

For this chapter, a grey literature search was performed, including a web search on the following websites: the FNAMS (Fédération Nationale des Associations Médico-sociales)[q]; the RIZIV/INAMI (National Institute for Health and Disability Insurance or NIHDI)[r]; the Federal Public Service Health, Food Chain Safety and Environment[s]; the European Observatory on Health Systems and Policies[t] ; the WHO Department of mental healthand substance abuse[u] Overlegplatforms Geestelijke Gezondheid van Vlaanderen en Brussel, Plate-formes de concertation en santé mentale des Provinces Wallons, Psychiatrieverband der Deutschsprachigen Gemeinschaft Belgiens[v]; Juriwel (de Vlaamse welzijns-, gezondheids- en gezinsregelgeving)[w] ; Wallex (Base de données juridiques de la Région wallonne)[x] ; Vlaams Agentschap Zorg & Gezondheid[y]; la Région wallonne et la Commission communautaire française de la Région de Bruxelles-capitale[z] ; l'Institut Wallon de Santé Mentale[aa] ; LUCAS Centrum voor zorgonderzoek & consultancy[bb] .

No information (references, data…) has been included after December 31, 2009.

7.2 GENERAL ORGANIZATION OF THE BELGIAN HEALTH CARE SECTOR

The Belgian health system is mainly organized on two levels, i.e. federal and regional. Since 1980, part of the responsibility for health care policy has been devolved from the federal Government to the regional governments. Responsibility for health care policy is shared between the federal Government, exercised by the Federal public service health, food chain safety and environment, the Federal public service social security, the National institute for health and disability insurance, and the Dutch-, French- and German-speaking community Ministries of health (Corens D. Health system review: Belgium)[cc]. The federal Government is responsible for the regulating and financing of the compulsory health insurance; determining accreditation criteria for hospitals; financing hospitals and so-called heavy medical care units; legislation covering different professional qualifications; and registration of pharmaceuticals and their price control. The regional governments are responsible for health promotion; maternity and child health services; different aspects of elderly care; the implementation of hospital accreditation standards; and the financing of hospital investment. Besides this, the regional governments are also responsible for most aspects of chronic care, housing etc.

The Belgian health system is based on the principles of equal access and freedom of choice, with a Bismarckian-type of compulsory national health insurance, which covers the whole population and has a very broad benefits package. Compulsory health insurance is combined with a private system of health care delivery, based on independent medical practice, free choice of service provider and predominantly fee-for-service payment to the service provider.

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q http://www.fnams.be/
r http://www.riziv.fgov.be/homenl.htm
s https://portal.health.fgov.be/portal/page?_pageid=56,512879&_dad=portal&_schema=PORTAL
t http://www.euro.who.int/observatory;
u http://www.who.int/mental_health/en/
v http://www.overlegplatformsggz.be/Overlegplatforms_Geestelijke_Gezondheidszorg_van_V/60/ggz; http://www.overlegplatformsggz.be/Wallonie/3253/ggz; http://www.psychiatrieverband.be/
w www.juriwel.be/
x http://wallex.wallonie.be/index.php?mod=accueil;
y http://www.zorg-en-gezondheid.be/
z http://www.wallonie.be/fr/citoyens/sante-prevention-et-securite/index.html; http://www.cocof.irisnet.be/site/fr/SiteMap/index_html; http://www.cocof.irisnet.be/site/fr/sante/Files/DECRET_AMBU/;
aa http://www.iwsm.be/institut-wallon-sante-mentale.php?idt=1
bb http://www.kuleuven.be/lucas/; http://www.steunpuntwvg.be/;
cc Corens D. Health system review: Belgium. Health Systems in Transition,2007; 9(2): 1–172.

7.3 GENERAL FINANCING OF THE BELGIAN HEALTH CARE SECTOR

7.3.1 General principles

The Belgian health system is primarily funded through social security contributions and taxations. According to the European "Health for all database" (hfa-db), in 2005 total health expenditure as a percentage of gross domestic product (GDP) in Belgium was 9.6%, of which public health expenditure amounted to 7,1% (Avalosse 2008)[178].

Each year since 1995, the government decides the legal growth norm applied to the public health care system. Introduced in 1995 and expressed in real terms, this norm has risen from 1.5% in 1995 to 2.5% in 1999 and 4.5% in 2004. Each year, a global budget and partial budgets are fixed by the general Council and the Committee for health Insurance where all the health care stakeholders are represented (care providers like physicians or dentists, mutualities, organizations of employers, trade unions employees, health care institutions like hospitals). In Conventions and Agreement Committees, the insurers (mutualities) and the care providers organize the health system on the field. They decide the contents of the 'nomenclature', the tariffs and the co-payments for each medical activity and service. In the context of the budgetary procedure, they have to determine, yearly, the needs of each health care sector (specialists and general practitioners, hospitals, drugs, nursing homes, rehabilitation, etc.). When a budget is exceeded, the members of these Committees are responsible for the elaboration of control measures (reduction of tariffs, increase of co-payment, revision of reimbursement conditions etc.).

Belgian health professionals are mainly remunerated through a fee-for-service system, which applies to medical and medico-technical services (consultations, laboratories, medical imaging and technical procedures) and paramedical activities (e.g. physiotherapy). The basic feature of Belgian hospital financing is its dual remuneration structure: services of accommodation (nursing units) and nursing activities in the surgical department are financed via a fixed prospective budget system based on diagnosis-related groups (DRGs); whereas medical, medico-technical and paramedical services rely on the fee-for-service system.

7.3.2 The statutory insurance system

In Belgium, we can distinguish two statutory insurance systems for health care costs covering: the 'general system for salaried workers' and the system for 'self-employed'. Beside these systems, we find the complementary insurance system, organised by the mutualities and the 'facultative' insurance system organised by the mutualities and the private companies. In 2005, it was calculated that the public health expenditures represented 77% of the total health expenditures[178].

The regulation and financing of the statutory insurance system belongs to the responsibility of the federal government; and the mutualities are responsible for reimbursement of the health care costs of their members. Since 1995, Belgian mutualities receive a prospective budget from the National Institute for Health and Disability Insurance (NIHDI, RIZIV/INAMI)[dd] to finance the health care costs of their members. They are held financially accountable for a proportion of any discrepancy between their actual spending and their so-called normative, i.e. risk-adjusted, health care expenditures. The reimbursement level of services provided depends on the employment situation of the patient (self-employed or employed, until 2007), the type of service provided, the statute of the person who is socially insured (preferential reimbursement or not) as well as the accumulated amount of user charges already paid. Patients in Belgium participate in health care financing via co-payments.

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dd The National Institute for Health and Disability Insurance, which acts as an intermediary between the whole of the Social Security and the mutualualities. It plays a role in the allocation of financial resources and in the establishment and control of current legislation.

7.3.3 The complementary insurance system

It is estimated that 2,9 % (0,8 billion euros) of the net total health expenditures are covered by the complementary insurances of the mutualities[179]. The members of the mutualities pay compulsory or optional primes to be covered for health services and goods not covered by the statutory insurance system. The complementary insurance is different for all the mutualities and the 'solidarity' is limited to the members of the same mutuality.

7.3.4 The private system

Beside the statutory and complementary insurance, private health insurances cover a part of hospitalisation costs[ee]. In 2005, the interventions of these insurances companies represent 2,3 % of the net total health expenditures. This private covering of health cost is relatively marginal but increases constantly; in 1998, they covered only 1.5% of the net total health expenditures.

7.4 GENERAL ORGANIZATION AND FINANCING OF SUPPORT SERVICES FOR PEOPLE WITH DISABILITIES

Services for disabled persons

The regional Governments are responsible for the provision and financing of long-term care for disabled persons: VAPH or Vlaams agentschap voor personen met een handicap; AWIPH or Agence wallonne pour l'intégration des personnes handicapées; DPB or Dienstelle für Personen mit Behinderung; for the specific situation of Brussels see Appendix[ff] Figure A.1 and website COCOF[gg]. Their offer is very diverse and consists of settings for residential care, semi-residential care, day care, short-term care, respite care, reference centres, services for support at home, sheltered workshops (beschutte werkplaats, entreprise de travail adapté) …

Public Welfare services

Several services depending on the level of municipalities and provinces, are in charge of help and support in the domain of Public Welfare, e.g. services for social housing, financial support, help at home for domestic tasks (familiale hulp, aide à domicile) etc. These services are open to persons with several types of psycho-social problems.

7.5 ORGANIZATION OF THE MENTAL HEALTH CARE IN BELGIUM

We focus our analysis on the general adult psychiatry. This means that we do not take into account the child and adolescent psychiatry. We also do not focus on those care settings that are specifically organized for elderly persons, but services for adults that are also open to elderly persons will be included. Since in the literature review of this report the care organization for addiction and forensic psychiatry are not included (see chapter 2), no specific attempts were made to find information on these subjects. However, when information on these two subjects seems to be necessary to clarify the global context, it will also be mentioned.

The literature review in this report only deals with care organization for persons with severe and persistent mental illness (SMI). Since it is difficult to describe the mental health care organization on the level of a country specifically for the SMI group, the country descriptions will include the full mental health care organization. However, the field of prevention and health promotion will not be dealt with.

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ee There exists private insurance covering also ambulatory costs but the extend of these insurances is limited

ff for *mental* health care and social support in Brussels, see Appendix Figure A.2 and website COCOF

gg http://www.cocof.irisnet.be/site/fr/sante/Files/TAB_SANTE_SOCIAL_BXL_09/

7.5.1 Historical context[hh]

7.5.1.1 The reform of 1990: psychiatric nursing homes, initiatives of sheltered living, psychiatric home nursing, and consultation platforms

Like elsewhere in Europe, the Belgian psychiatric reform that was started in 1990 is characterized by the will to take care of persons with a mental disorder out of the hospitals, and by the movement of substitution between hospital beds and other forms of residential or ambulatory care. The laws of July 1990 have created new care structures: the *psychiatric nursing home* (PNH) (maisons de soins psychiatriques – psychiatrische verzorgingstehuizen) and the *initiatives of sheltered living* (ISL) (initiatives d'habitations protégées – beschut wonen)[ii]. The law of 1991 also lined out the conditions for psychiatric hospital services to organize *psychiatric home nursing* (Tf) (places de soins psychiatriques en milieu familial – psychiatrische gezinsverpleging). This means that the person with a mental disorder lives with a foster-family supported by professional services, but at the same time a certain number of hospital beds serve as back-up in case the patient should need hospitalization.[jj] The creation of these three new structures was accompanied by the reduction of the number of psychiatric beds by compulsory and voluntary reconversions of hospital beds into beds in PNH and places in ISL or Tf. In the same Laws we find also the conditions for the creation of '*consultation platforms*' (plates-formes de concertation psychiatrique – overlegplatforms ; see below). The most important goal of these platforms consists in the dialogue about the regional coordination of the different existing and new forms of medical and psychosocial supply for persons with a mental disorder.

7.5.1.2 The reform of 1999: planning of PNH, ISL and Tf

The process of reconversions was promoted by new laws edited in 1999 giving precise conversion rate between hospital beds and from hospital beds (psychiatric beds and other hospital beds) into PNH beds[kk] and ISL[ll] or Tf places[mm]. The goal of the reconversions was to provide all types of care organizations in each region and community. Per thousand inhabitants 0,6 beds are planned for the PNH and 0,5 places per thousand inhabitants for the ISL. The maximal number of patients in the Tf system was fixed on 975 for the whole country, and for these patients a maximum of 145 hospital places could be foreseen. (Additional Tf places/beds were made possible by the law of 29-09-2000, which did not fix a maximal number of Tf places/beds anymore). It was also decided to re-invest 10% of the economy resulting from the reconversions back in the hospitals and services taking part in the reconversions. A part was dedicated to the employment in the hospital (7.5% of the economy) and a part (2.5% of the economy) to the budget of the hospital by means of an increase of the "daily fee" (increase of the B4 part of the psychiatric hospital which is dedicated to projects of quality promotion of psychiatric care).

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hh For this historical part, we base our text mainly on the information found on the site of the Fnams (http://www.fnams.be; http://www.fnams.be/LOGINONE/levelone/geest_gezondheidszorg/gghp.asp)(Fédération Nationale des Associations Médico-Sociales).

ii A.R. and A.M. 10th July 1990

jj A.R. 10th April 1991

kk A.R. 16th June 1999 (MB 29th September 1999) modified by A.R. 18th February 2000 (MB 16th March 2000), A.R. 14th April 2001 (MB 26th October 2001) and A.R. 03rd July 2005 (MB 12th August 2005). See also A.R. 23rd June 2003 (MB 07th August 2003) and A.R. 19th March 2007 (MB 13th April 2007)

ll A.R. 16th June 1999 (*MB* 29th September 1999) modified by A.R. 18th February 2000 (MB 16th March 2000), 05th June 2000 (MB 14th July 2000), 14th September 2001 (MB 26th October 2001) and 10th November 2005 (MB 13 December 2005)

mm A.R. 10th April 1991 (*MB* 30th April 1991) modified by A.R. 12th October 1993 (MB 19th October 1993) and A.R. 16th June 1999 (MB 29th September 1999)

7.5.2 Third reformation wave: care circuits and networks of care

7.5.2.1 Political and legal context

The concept of Care circuits and networks of care

Already after the first reform wave of the early nineties, it was clear that additional measures would be necessary to develop further the principles put forward at the beginning of the reformation. Therefore, the National council for hospital supplies (Nationale raad voor ziekenhuisvoorzieningen (NRZV), Conseil national des établissements hospitaliers (CNEH)), an advisory committee at the Federal public service for health, food chain safety and environment, mandated its Permanent psychiatric working group to formulate these advices. A first advice was formulated on 15th May 1997, followed by many others that, on request of the Ministers, have been brought together in one synthetic document[nn] that has been approved on 21st June 2002. The main principles of this document don't rely on a reconversion but a new content for the mental health care organization in Belgium is formulated.

A specific legal context for some of these new principles had already been created in January 2002, to define the concepts of 'networks of care' and 'care circuits'[oo]. A '*care network*' is a whole (i.e. an aggregate) of caregivers, care organizations and services depending on the federal authority, which proposes to a 'target group' one or several care circuits. A '*care circuit*' is a whole of care programs and services depending on the federal authority, organized by a network of care organizations, and dedicated to one 'target group' or a 'sub target-group'.

2002: Declaration on the future mental health care policy

On 24th June 2002, the Ministers responsible for Health at the federal, regional and community level, all signed a common declaration about the future mental health care policy.[pp] This declaration is based on the advice of the NRZV/CNEH (21st June 2002); and it refers to the WHO report (2001) on the challenging evolution of the psychiatric and psychological problems in the world. The declaration contains 4 main points:

1. The need of a new concept of mental health care

The Ministers insist strongly to give a central place in the organization of care to the person with a mental disorder. To realize this and to optimize mental health policy, they propose a closer collaboration between all the authority levels by the organization of a Task Force. This Task Force should become responsible for the elaboration of proposals submitted to the inter-ministerial conference.

2. The basic organizational principles of the future mental health care

Mental health care has to be organized around the needs of the person with a mental disorder and, if possible, in his natural living environment. Care should be adjusted to the specific needs of each person with a mental disorder and his family ("tailored care"). Three main target groups should be distinguished: children and adolescents, adults, and the elderly. A specific 'care circuit' has to be developed for each of these groups. The future care supply will be developed starting from the actual system which has to be adapted and completed, to lead to a coordinated system of services, in which continuity of care is an important element. This makes the development of "care networks" between different service providers and professionals necessary. Coordination and collaboration between the different authority levels should also be put in place. Finally, prevention and promotion of mental health will be developed to guarantee the welfare of all citizens.

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nn https://portal.health.fgov.be/pls/portal/docs/PAGE/INTERNET_PG/HOMEPAGE_MENU/GEZONDHEIDZORG1_MENU/OVERLEGSTRUCTUREN1_MENU/NATIONALERAADZIEKENHUISVOORZIENINGEN1_MENU/NATIONALERAADZIEKENHUISVOORZIENINGEN1_DOCS/2002%2007%210%20-%20NRZV%20D%20PSY%20209-2%20NL.PDF

oo See the article 9ter of the hospital law introduced by the Law of 14th January 2002

pp See MB 23rd May 2005

3. Priority will be given to children and adolescents (on request of the Task force enlarged on 24-5-2004 to persons of any age, suffering from a chronic and complex psychiatric disorder).

2005: the concept of Therapeutic projects and Transversal Conversations

In May 2005, the federal Minister of social affairs and public health Rudy Demotte, published a document[qq] about mental health care organization, where he explains the challenges addressed at the mental health care system. He concludes that "Therapeutic projects" should be developed, which are meant to try out new initiatives aiming at creating care circuits and care networks and preparing a structural and definitive implementation of care circuits and care networks for persons with a chronic and complex mental disorder. This should enable a more integrated approach to guiding these patients through the different types of care provision. Although the definitions of "care circuit" and "care network" only include services under federal authority, the Minister proposes to include services and care organisations depending on regional or community authorities. Whereas the Therapeutic projects are meant to prepare circuits and networks at the patient level, it is also necessary to prepare these circuits and networks at an organizational and population level; therefore the "Transversal Conversations" will be developed (see further).

On 23 Dec 2009, a Royal decree[rr] (article 107) concludes that "care networks" and "care circuits" can be financed temporarily and on an experimental base ("experimental projects"), according to the national law for hospital funding. This opens the way to anchor the Therapeutic projects to the regular hospital funding. The first proposals for the organization of such experimental projects are underway[ss]

7.5.2.2 Third reformation wave: implementation

The Consultation platforms

In 1991, a first step towards the general idea of developing continuity of care and collaboration between different mental health services had already been realized by the creation of the "consultation platforms"[tt] active in all the regions: five in the Flemish region, one in the Brussels region, seven in the Walloon en German regions. These platforms are financed by the Federal Government. They aim at consulting with the different mental health care organizations in their region to optimize the diversity and complementarity of the care supply, and to promote collaboration. Each platform consists of psychiatric services of general hospitals, psychiatric hospitals, PNH, ISL, ambulatory mental health care centers and rehabilitation centers for persons with mental disorders, belonging to the region of the platform. Each platform also has to organize an ombudsservice to mediate between patients raising a complaint and the care providers of the region. One federal umbrella platform (connected with the Federal public service for health, food chain safety and environment) is in charge of the contacts between the 13 platforms and the policy makers.

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qq https://portal.health.fgov.be/pls/portal/docs/PAGE/INTERNET_PG/HOMEPAGE_MENU/GEZONDHEIDZORG1_MENU/GESPECIALISEERDEZORGEN1_MENU/GEESTELIJKEGEZONDHEID1_MENU/PUBLICATIES41_HIDE/PUBLICATIES41_DOCS/PSY_2005_001_BELEIDSNOTADEF_GGZ_25_04_05%20.PDF

rr See MB 7nd November 2008; amendments of 23th Dec 2009 (article 107)

ss https://portal.health.fgov.be/portal/page?_pageid=56,512828&_dad=portal&_schema=PORTAL

tt Plates-formes de concertation psychiatrique – Overlegplatformen ; https://portal.health.fgov.be/portal/page?_pageid=56,512646&_dad=portal&_schema=PORTAL; www.overlegplatformsggz.be; http://www.fnams.be/LOGINONE/levelone/geest_gezondheidszorg/ggopso.html;

Pilot projects started in 2001

In 2001, the federal Government started up several pilot projects[uu] as a next step to realize care circuits and networks. The Federal public service for health, food chain safety and environment, and more specifically its Service of psychosocial health care (Dienst psychosociale gezondheidszorg, Service des soins de santé psychosociaux[vv]) hosts and finances these projects. They are meant to try out new organisational structures or a specific care offer; some of them are set up around a specific problem group. If the projects succeed, policy makers can be advised on the necessary conditions before the new care structure is legally adopted.

Of all the different projects, the projects 'psychiatric care for patients in the home environment' became by law linked to the ISL and structurally financed by the Royal decree of 17th March 2009[ww]. On the other hand, so far only the projects 'activation' (see below) have been put to an end and left to the Ministry of Work, because only 8% of the participants returned back to work. The other projects have been, as far as possible, included in the Therapeutic projects started in 2007 (see further). Besides the projects for adults described below[xx] (including projects related to addiction), there were 4 projects for children and adolescents.

- By means of supportive counselling, the 19 projects 'activation' focused on stimulating the social inclusion of chronically mentally ill persons in the field of work and education. These projects had to be established by an initiative of sheltered living, but other target groups than the ISL residents had to be included as well.
- The 29 projects 'psychiatric care for patients in the home environment' aim at making care providers in home care aware of this target group, coaching them, and guaranteeing co-ordination of the care. The final purpose is an improved co-operation between the actors of the regular home care and the actors in mental health care. This can help, for example, to avoid admission in hospital in times of crisis. The participation of an initiative of sheltered living is compulsory.
- In the 4 projects 'persons with severely disturbed behaviour and/or aggressive behaviour (SGA)' separate units of 8 beds each are established for this target group. They offer specific programs for a limited period aiming at decreasing the most severe behavioural disturbances.
- The 6 projects 'commitment/internment' provide an intensive clinical treatment in a separate unit of 8 beds each, for detainees free on probation, aimed at reintegration in society. There is an additional financial support from the federal Government department of Justice.
- The 2 projects 'double diagnosis' offer a specific treatment for patients with an addiction problem in combination with psychotic psychiatric problems. The purpose is to at least stabilize the patient and if possible to realize a transfer to another relevant ambulant or residential setting.
- Nine pilot projects established crisis units for patients with addiction problems and a case manager has been implemented in these units. The short treatment aims at resolving the crises; the case manager is responsible for the continuity of care during the admission and at discharge.
- The pilot project 'implementation of the function care co-ordinator for the treatment of persons with addiction problems' is embedded in the 13 consultation platforms. The purpose is to facilitate care trajectories.

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uu see also KCE report 84 "Long stay patients in T-beds", p 149

vv https://portal.health.fgov.be/portal/page?_pageid=56,512828&_dad=portal&_schema=PORTAL

ww see RD 17th March 2009

xx https://portal.health.fgov.be/portal/page?_pageid=56,911986&_dad=portal&_schema=PORTAL

- The projects 'discharge management in psychiatric hospitals' try to establish a bridge between hospitals and the domestic environment of a patient in order to avoid the risk of discontinuity of care. This is realized through systematic and patient oriented preparation of the discharge in consultation with the extramural actors.
- Three projects on "care for persons that committed an attempt of suicide" aim at developing education for hospital and first line professionals.
- One project organizes a mobile team ("outreach") providing mental health care to homeless people.
- One project evaluates the possibility to diminish the number of persons seeking help because of a psychiatric crisis at the emergency department. The project supports first line professionals (family doctors...) in charge of persons in crisis by telephone or by providing on-line information (referral possibilities, treatment guidelines...), so that referral to the hospital possibly can be avoided.

The Therapeutic projects started in 2007

In April 2007, eighty-two TP or Therapeutic projects[yy] were launched[zz]. Each TP includes at least one partner organization of the first-line (family doctor, home nursing, home care coordinating service (geïntegreerde dienst voor thuiszorg (GDT) services intégrés de soins à domicile (SISD)), second-line (mental health care centre (centrum voor geestelijk gezondheidszorg (CGGZ), service/centre de santé mentale (SSM)) and third-line level (psychiatric service of general hospital or psychiatric hospital). The TP, based on local initiatives (bottom-up approach), are subdivided in projects for children, for adults and for elderly, and many different target-groups are included (Psychotic or depressive disorders, borderline or other personality disorders, attention-deficit-and-hyperactivity disorder (ADHD), combined psychiatric problems and mental retardation, addiction, forensic psychiatry, social psychiatry...). Four meetings per patient per year of the different participating care organizations of the project are mandatory. The projects are run for three years, and scientific follow-up should make an objective evaluation possible. Reimbursement is foreseen by the NIHDI (RIZIV/INAMI) and includes a global fee for the coordination of the project, as well as a fee for each meeting of the participating care organisations where the problems and the coordination of care for one specific patient are discussed. A significant budget has been contributed by the SPF, The NIHDI budget amounts to +-Euro 2 200 000/year.

Besides the patient-centred meetings within one project, there are general meetings for all projects of a specific cluster; in these meetings the different care organizations of the cluster projects can participate, as well as patient and family organizations. The purpose of these "Transversal meetings"[aaa] is to discuss the general approach in the projects, the specific added value of the network and care coordination approach, as well as the encountered organizational problems.[bbb] The meetings are organized by the regional consultation platforms. Evaluation of the meetings and general conclusions are also under the responsibility of the regional consultation platforms. The Federal public service (FPS) for health, food chain safety and environment finances these meetings and the gathering of the necessary data to evaluate the projects; the yearly budget amounts to +-Euro 2 795 000. The Federal health care knowledge centre (KCE) is involved in the scientific evaluation of the data.

It should be noted that in 2007, as much as possible, the existing Pilot projects that started in 2001, were included in the TP.

More details on the TP are published in other KCE reports (see KCE reports 103 and 123)

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yy http://www.riziv.be/care/nl/mental-health/therapeuticProjects/

zz see Royal decree of 22nd Oct 2006

aaa http://www.transversaaloverleg.be/

bbb http://www.transversaaloverleg.be/documenten/Basisdocumenten/NRZV%20-%20deeladvies%202%20en%203%20over%20TO.pdf

The "Experimental" projects

On 23 Dec 2009, a Royal decree (article 107) concludes that "care networks" and "care circuits" can be financed temporarily and on an experimental base, according to the national law for hospital funding. Based on this Decree, the SPF will develop "experimental projects" as a temporary step to realize care circuits and networks within the structures of the hospital financing[ccc]. The "therapeutic projects" will be put to an end. The collaboration of the regionally funded ambulatory mental health care centers has been assured by an agreement of the Interministerial conference.

Examples of projects not funded by the government

Apart from the new initiatives supported by the federal Government, some care organizations with a substantial experience in psychiatry start one or more projects in domains that are not (yet) or not fully covered by the Government. Many examples exist; a few of them will be mentioned below.

- The VRINT project[ddd] started in Jan 2009 and is run by the University Psychiatric services centre "St Jozef Kortenberg". A multidisciplinary team, embedded in a local network of other care providers, can be contacted for an early diagnosis and/or first intervention in case of early psychosis (adolescents and young adults of 15-30 years). The goal of the team is to intervene early, at the first signs of a psychosis, with the aim to improve later outcome. Also in Antwerpen, Halle-Vilvoorde, Sint-Niklaas and Brugge, a similar project (VDIP-team) has been started.
- In 2006, a project "Assertive Community Treatment (trACTor)" was launched by the psycho-social centre "St-Alexius-Elsene"[eee]. The team coordinates and provides multidisciplinary interventions in the community for persons with a chronic mental disorder, usually associated with several social problems as well. The pilot project aims to develop guidance for other starting ACT-teams in Belgium. Initially it was funded by the "Koning Boudewijn/ Roi Baudouin Foundation" and a pharmaceutical company; but since 2007 funding is foreseen in accordance with the terms of the Therapeutic projects.
- Between 2003 and 2007 the province of East-Flanders subsidized a project on mental health care circuits for the elderly. The care circuits that were developed during the project are still continued and follow-up is provided by the East Flanders consultation platform.[fff] Participating care providers learned that it is better to provide mental health care support in the usual care circuit for elderly people, rather than transferring these persons with mental health problems to the specialized mental health care services.
- The "Netwerk psychiatrische zorg in de thuissituatie, Regio Groot-Gent"[ggg] participates in the governmental projects 'psychiatric care for patients in the home environment' that are linked to the ISL, but additionally to the personnel financed by the Government (2 FTE), 2.6 other FTE are financed by the partners of the Network.

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ccc http://www.health.belgium.be/eportal/Healthcare/index.htm

ddd http://www.vrint.eu/; http://www.vvp-online.be/nl/activiteiten/2009/project_vrint_vroegtijdige_interventie_bij_vroege_psychose-290.html

eee http://www.psc-elsene.be/

fff http://www.popovggz.be/documenten/Activiteitenverslag%202008.pdf

ggg http://www.psytzgent.be/netwerk%20psychiatrische%20thuiszorg%20Gent.htm

7.5.3 Data collection, scientific institutes

Data collection

- - The collection of Minimal psychiatric data (MPD) (Minimale psychiatrische gegevens (MPG), Résumé psychiatrique minimum (RPM)) is obligatory for Psychiatric hospitals, psychiatric departments of general hospitals, PNH and ISL. The anonymous data of all stays of residents is passed on to the federal Government (Federal public service for health, food chain safety and environment[hhh]). The data is collected at the beginning and at the end of residential treatment (a stay), as well as after each significant period in the treatment (e.g. when the residents moves to another treatment unit) or at least each 6 months.

The data collection is extensive, although no validated outcome measures are included: patient socio-demographic data are detailed, a lot of attention is paid to functional impairments (and not only medical diagnosis) and to all types of help the residents might need (not only medication). Collected are:

socio-demographic data, living environment before start of the residential care, educational level and occupation, psychiatric diagnosis (DSM-IV), details of the existing problems on several domains (psychological, social, relational, physical...), therapeutic goals (stabilization of symptoms, improvement, total cure), relevant professional acts during stay (help with activities of daily living, supervision on safety, diagnostic and therapeutic acts (psychotherapy, group therapy, physiotherapy...); medication classes prescribed, living environment after leave (at the end of stay).

Scientific institutes, Reference centers for mental disorders

- -Walloon Institute for Mental Health (Institut Wallon pour la Santé Mentale, IWSM[iii]): founded in 2002, this institute brings the different stakeholders in mental health care together, including professional associations and policy makers as well as associations for persons with mental disorders and their family. The aim is to discuss and reflect on issues of treatment, organization as well as ethics. The IWSM is also responsible for research, education and dissemination of information. It is composed of a multidisciplinary team, and funded by the Walloon region.
- - Reference centres for mental disorders: the Walloon regional Government decided by Decree on 3rd April 2009, to create and fund (a) reference centre(s) (centre(s) de reference en santé mentale). These centre(s) are/is responsible for the care coordination between ambulatory centres for mental health care and other mental health care providers; they are/ it is also responsible for education and support of these local centres, and eventually for research and data analysis.
- -Several other research teams, mostly linked to a university, are active in the field of (organization and financing of) mental health care.

7.5.4 Mapping of existing services

We use the 'Service Tree' developed by Johnson et al. to map the mental health services[5]. This 'Tree' distinguishes five main different structures of mental health services: secure, residential, day & structured activity, out-patient & community and self-help & non professional services. The second, third and fourth structures are developed as a tree to take into account the differences between acute and non-acute cares, emergency and continuing care but also the care duration and intensity (and eventually whether mobile care supply is possible or not).

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hhh https://portal.health.fgov.be/portal/page?_pageid=56,512879&_dad=portal&_schema=PORTAL

iii http://www.iwsm.be/institut-wallon-sante-mentale.php?idt=1

We present a synthetic table of all the existing services applying the ESMS tree and we describe the organizational and financial aspects of each of them in the following sections. We distinguish '**Full mental health services**' depending of the psychiatric sector, from the **Mixed services** ('Residential mixed services' and 'Mixed support teams'). We find 'full mental health services' in almost all categories of the Service Tree developed by Johnson (the figures in brackets refer to the synthetic Table). Residential mixed health services and mixed support health and social teams concern a broader group of patients or persons with social problems. The mixed teams are only ambulatory services. These types of services will be generally dealt with.

Only services for which a specific legal context exists will be mentioned in this Service tree. Pilot projects, therapeutic projects or other experimental settings will not be mentioned here.

Table: Synthetic presentation of the ESMS tree

SECURE **(1)**			
RESIDENTIAL	Generic acute	Hospital **(2)**	
		Non-hospital **(3)**	
	Non-acute	Hospital **(4)**	Time limited **(4.1)**
			Indefinite stay **(4.2)**
		Non-hospital **(5)**	Time limited **(5.1)**
			Indefinite stay **(5.2)**
DAY & STRUCTURED ACTIVITY	Acute **(6)**		
	Non-acute **(7)**	High intensity **(7.1)**	
		Low intensity **(7.2)**	
OUT-PATIENT & COMMUNITY	Emergency care **(8)**	Mobile **(8.1)**	
		Non-mobile **(8.2)**	
	Continuing care **(9)**	Mobile **(9.1)**	
		Non-mobile **(9.2)**	
SELF-HELP & NON-PROFESSIONAL **(10)**			

7.5.4.1 The 'full mental health' services

We begin with the list of the 'full mental health services'; the numbers refer to Table 6:

- Full time hospital care : 2 & 4
- Part-time hospital care (night or day): 4 & 7
- Psychiatric home nursing : 5
- Initiatives of sheltered living (initiatives d'habitations protégées – beschut wonen) : 5
- Psychiatric nursing home (maisons de soins psychiatriques - psychiatrische verzorgingstehuizen) : 5
- Therapeutic communities, half-way houses, night centres : 5
- Day centres, therapeutic clubs : 7
- Centres for crisis intervention : 8.2
- Outreach (street workers) for drug addiction: 8.1 and 9.1
- Mental health centers (centres ou services de santé mentale – centra voor geestelijke gezondheidszorg) : 9.2
- Rehabilitation centers (centres de réhabilitation – revalidatiecentra) : 9.2
- Postcure care : 9.2
- Ambulatory care givers (psychiatrists, psychotherapists, psychiatric nurses) : 8 & 9

7.5.4.2 *The 'residential mixed' services (5.1 & 5.2) and the "mixed support teams" (7 & 9)*

Services for disabled persons

The regional Governments (VAPH or Vlaams agentschap voor personen met een handicap; AWIPH or Agence wallonne pour l'intégration des personnes handicapées; DPB or Dienstelle für Personen mit Behinderung; the Service Bruxellois francophone des personnes handicapées (SBFPH)) are responsible for the provision of long-term care for disabled persons. This offer is very diverse and consists of settings for residential care, semi-residential care, day care, short-term care, respite care, reference centres, services for support at home, sheltered workshops (beschutte werkplaats, entreprise de travail adapté) …

Different types of handicaps are accepted in these "mixed" settings, e.g. mental retardation and physical handicaps. However, persons with a primary diagnose of a mental disorder (schizophrenia, severe depressions…) do not belong to the target groups under the responsibility of the regional Governments. This is probably a consequence of the historical reconversion operations in the psychiatric sector.

One exception are persons with autism spectrum disorders, which do fall under the responsibility of the regional Governments, as concerns long-term care. Probably this is due to the fact that they are considered to suffer from congenital developmental disorders with the first signs and symptoms appearing early in life, as opposed to persons with "classical" primary diagnoses of mental health disorders. A group for which it is less clear where they can find long-term care, is the group of persons with Acquired brain injuries.

Services of Public Welfare

Several services depending on the level of municipalities and provinces are in charge of help and support in the domain of Public Welfare, e.g. services for social housing, financial support, help at home for domestic tasks (familiale hulp, aide à domicile) etc. These "mixed" services are also open to persons with mental disorders, but no figures on the number of users with a mental disorder are available.

Some initiatives have been taken to improve the collaboration between these services for Public Welfare and the ambulatory mental health care services, e.g. the temporary financial support for this kind of collaboration from the Flemish Ministry for Welfare, Public Health and Family (2008)[iii]

7.5.5 The 'Mental health care tree' in Belgium

A table with an overview of available services in Belgium is presented in chapter 14.1.6.

7.5.5.1 *Secure services (1)*

Out of scope of this report.

7.5.5.2 *Residential mental health services*

- Residential, generic Acute; hospital (2) or non-hospital (3)

Hospitals with units with letters A (day and night), a1 (day treatment) and a2 (night treatment) (see also further Residential, non-acute, hospital (4)), can provide residential care in case of crisis. Specific hospital emergency units for psychiatric patients (addiction) currently only exist as experiments.

- Residential, Non-acute
  - Residential, non-acute, Hospital (4)

[iii] http://www.zorg-en-gezondheid.be/nieuws/700000_voor_CGG.aspx

In Belgium, hospitals can be classified into two categories: general and psychiatric. In 2005, there were 116 were general (non-specialized) hospitals[kkk] and 69 psychiatric hospitals. Funding of Belgian hospitals belongs to the responsibility of the federal Government.

In both types of hospitals, one can find several types of units (K for children (not further described), A or T for adults, Sp6 for elderly). The indices with capital letters (A, T) characterize residential beds (full time hospitalization) and the ordinary letters (a, t) characterize beds where the patients find a place for the day (a1, t1) or the night (a2, t2) (part time hospitalization).

- Units for adults with letters A (day and night), a1 (day treatment) and a2 (night treatment) to observe patients, to start or change a treatment (or to provide care in case of crisis, see "Generic acute (2)).
- Units for adults with letters T (day and night), t1 (day treatment) and t2 (night treatment) where the treatment aims at a maximizing the (possibility of) social reintegration.
- Units for psychogeriatric care and rehabilitation (Sp6), meant for older persons with physical and mental health problems. The treatment intends a physical, mental and social recovery as good as possible.
- Units for psychogeriatric care named T-Vp (only in psychiatric hospitals), also meant for older persons with physical and mental health problems.

After a discharge from a psychiatric hospital, a patient can get an ambulatory follow-up treatment in the hospital during three months with a possibility of prolongation (system of post treatment, see further).

An overview for the year 2007, for Belgium and for the regions of Flanders, Walloon and Brussels, can be found in Table 7.1. Note that in 2007 Belgium had 10 584 534 inhabitants, of whom 57.8% (6,1 million) in the Flanders region, 32.5% (3,4 million) in the Walloon region and 9.7% (1,0 million) in the region of the capital Brussels.[lll]

It is clear from table 7.2 that many more places are available in Psychiatric hospitals (A-beds as well as T-beds, 82%; A-beds 66%, T-beds 98%) as compared to Psychiatric services of general hospitals (18%); the latter provide almost only A- or a-beds. By law, per thousand Belgian inhabitants 0.9 places are planned for T-beds (+-9000 places for Belgium) and 0.4 for t1 (day treatment); this means that the legal norm for T-beds has not been reached.

In Psychiatric hospitals 15% of the places are reserved for part-time hospitalization; in Psychiatric services of general hospitals 10%.

kkk excluding specialized hospitals and geriatric hospitals.

lll http://www.plan.be/admin/uploaded/200805081112550.pp105_nl.pdf

Table 7-1: Available places for persons with a mental disorder in 2007 in Belgium and in the region of Flandres, Walloon and Brussels. (Source: Federal public service for health, food chain safety and environment)/ (*): Additionally 15 night- or week-end places are available in Brussels (2009) under a NIHDI 772-Convention.

		Belgium	Flandres	Walloon	Brussels
Psychiatric hospitals (Residential+Day/night)		**13443**	**8461**	**4021**	**961**
	A	4686	2884	1354	448
	K	474	209	205	60
	T	5626	3415	1916	295
	Sp6	576	405	171	0
	T-Vp	764	644	120	0
Psychiatric hospitals Residential (A+K+T+Sp6)		*11362*	*6913*	*3646*	*803*
Psychiatric hospitals Day or Night Treatment		*2081(*)*	*1548*	*375*	*158*
Psychiatric Departments General hospitals (Residential+Day/night)		**3010**	**1537**	**1075**	**398**
	A	2404	1240	854	310
	K	214	131	35	48
	T	90	0	90	0
	Sp6	583	154	286	143
	T-Vp	0	0	0	0
PD General hospitals Residential (A+K+T)		*2708*	*1371*	*979*	*358*
PD General hospitals Day or Night Treatment		*302*	*166*	*96*	*40*
Psychiatric Nursing Home		**3241**	**2240**	**799**	**202**
Running-down Places		781	738	43	0
Permanent places		2460	1502	756	202
Initiatives Sheltered Living		**3671**	**2486**	**751**	**434**
TOTAL		**23365**	**14724**	**6646**	**1995**

Table 7.2: Hospital supply in Belgium for persons with mental disorders, adults and elderly (places, 2007) (Source: Federal public service for health, food chain safety and environment)-NA: not available

Hospitalization Adults	Full-time (places)	Full-time (%)	Part-time Day/Night (places)	Part-time Day/Night (%)	Total (places)	Total (%)
Psychiatric hospitals Total	**10.888**	**81**	**2081**	**87**	**12.969**	**82**
of which acute	4686	66	NA	NA	NA	NA
of which non-acute	5626	98	NA	NA	NA	NA
General hospitals Total	**2494**	**19**	**302**	**13**	**2796**	**18**
of which acute	2404	34	NA	NA	NA	NA
of which non-acute	90	2	NA	NA	NA	NA
Total	**13.382**	**100**	**2383**	**100**	**15.765**	**100**
Total/100.000 general population	127,4	--	22,7	--	150,1	--
of which acute/100.000 general population	67,5	--	NA	--	NA	--

- Residential, non-acute, Non-hospital (5)

The **initiatives of sheltered living** (ISL) are a first possibility of residential non-acute care. An initiative of sheltered living is meant to house and support mentally ill persons not in need of a fulltime hospital treatment but, for psychiatric reasons, in need of specially adapted activities or professional help. Consequently the target group consists of chronically mentally ill but stabilized persons that cannot yet be fully reintegrated in society. The professional support aims at maximizing the independence of residents by learning them social and administrative skills, organizing useful time spending and stimulating contacts with the home environment. An ISL can shelter between 3 patients and 10 patients; 20% of the places have been foreseen for persons living individually. The professional team is composed by a specialist in (neuro-)psychiatry and per 8 inhabitants one FTE qualified as social nurse, psychiatric nurse, psychologist, criminologist, social assistant or occupational therapist.

In 2007, there are 3671 Belgian places (see Table 7.1). This means 34,9 places/100.000 population. By law, per thousand Belgian inhabitants 0.5 places are planned for the ISL (+-5000 places for Belgium)[mmm]; this means that the legal norm has not yet been reached.

Funding of the ISL belongs to the responsibility of the federal Government, through the NIHDI (RIZIV/INAMI). This is remarkable, since initiatives of sheltered living for other types of disabled persons, e.g. mentally retarded or physically handicapped persons, belongs to the responsibility of the regional governments[nnn] (VAPH or Vlaams agentschap voor personen met een handicap; AWIPH or Agence wallonne pour l'intégration des personnes handicapées ; DPB or Dienstelle für Personen mit Behinderung; for the specific situation of Brussels see Appendix Figure A.1 and A.2 and website COCOF[ooo]. Probably this situation is the consequence of the reconversion operations that took place in the nineties and the first years of this century.

mmm See A.R. 10th July 1990

nnn http://www.vaph.be/vlafo/view/nl/; http://www.dpb.be/; http://www.awiph.be/

ooo http://www.cocof.irisnet.be/site/fr/sante/Files/TAB_SANTE_SOCIAL_BXL_09/

The **psychiatric nursing homes** (PNH) are a second type of non-acute, non-hospital residential care. The regulation concerning the psychiatric nursing homes mentions explicitly that this type of setting is meant to offer care allowing shortening or avoiding a hospital stay. The emphasis is put on care (and not on cure) by activating the remaining capacities of residents and organising and offering meaningful activities during the day in a domestic atmosphere. There are two target groups: stabilized chronically mentally ill persons and mentally disabled persons. In both cases the patients require permanent support, but are not in need of hospital treatment or permanent psychiatric surveillance. Yet they are not eligible neither for an initiative of sheltered living nor for a classical nursing home for disabled persons due to their psychiatric condition.

In 2007, there are 3241 Belgian places or 30,9 places/100.000 population (see Table 7.1). Due to the legal instructions for the reconversion actions in 1990 and 1999, some of these places are running-down, which means that the resident taking this place will not be replaced after he left the PNH. A total of 781 places is running-down.

By law, per thousand Belgian inhabitants 0.6 places are planned for the PNH (+-6000 places for Belgium); this means that the legal norm has not yet been reached. Long waiting lists are reported[ppp]. Funding of the PNH belongs to the responsibility of the federal Government, through the NIHDI (RIZIV/INAMI). As for the ISL, this is remarkable, since initiatives of this type for other categories of disabled persons, e.g. mentally retarded persons, belong to the responsibility of the regional governments. The KCE report n°84 commented on the estimated out-of-pocket payments for the residents in PNH (and ISL), which are much higher than estimated out-of-pocket payments in T-hospital beds; for the Government the reverse is true. It has been estimated that there exist structural problems with the financing of several types of psychiatric residential care organizations; but this is out-of-scope of this report.

Psychiatric home nursing (Tf), a third type of non-acute residential care, was created by the Law in 1991[qqq]. Two psychiatric hospitals (one in Flanders (Geel) and one in Wallonia (Lierneux)) organize home nursing for persons with a mental disorder. This is a form of hospitalization for persons with mental disorders in need of constant support. The patient participates in the family live of a foster family and receives the care and support he needs. This care and support depends on a hospital psychiatric service and is provided by a multidisciplinary team depending on the hospital. Sometimes, general practitioners or ambulatory nurse services can also intervene. In the hospital, a minimal number of beds are reserved to the patients in observation, waiting for a sheltering family or to compensate for a temporary or definitive incapacity of the family[rrr].

In 2007, there are in Belgium 705 Tf-places in foster families, connected to 145 hospital places. This means 6.7 places/100.000 population.

A special type of Residential, non-acute, non-hospital settings are the **Therapeutic Communities** (TC) (Therapeutische gemeenschap, Communauté thérapeutique). The NIHDI finances TC under an agreement in which the conditions for reimbursement are stipulated (Convention 773-residential); in 2009 there were 369 places in Belgium or 3,5 places/100.000 population (see Table 7.4). In these TC, persons with an addiction problem live together, usually in small units of up to 10-15 persons, and try to overcome their problems with the help of each other and the professionals attached to the TC. A stay in a Therapeutic community can be followed by a stay in a "**Half-way house**", that still offers residential treatment but residents participate already more in every-day life. These Half-way houses usually depend on a Therapeutic community.

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ppp http://www.senate.be/www/?MIval=/index_senate&LANG=nl

qqq A.R. 10th April 1991 (MB 30th April 1991)

rrr The number of beds (labelled Tf) represent minimum 15% of the total of places in foster families

Other **Residential, non-acute, non-hospital settings for time-limited stay depending on the NIHDI** are open to several types of mental disorders; they aim at psycho-social rehabilitation for persons with a mental disorder that have difficulties with activities of daily living, professional or social functioning (NIHDI-convention 772-residential). In 2009, there were 89 places available or 0,8 places/100.000 population, see Table 7.3.

Within the framework of "mixed services" for persons with several types of psychosocial problems, a special type are **Night centres** for persons with psychosocial problems that need sheltering and help during the evening and at night, but have regular activities or work during the day.

Table 7.3: NIHDI agreements (Conventions 772) for residential non-hospital services and ambulatory rehabilitation of persons with mental disorders (Source: NIHDI 2009). (*): places x 8,3; extrapolation based on NIHDI study 1999.

Convention 772		Flanders	Brussels	Walloon region	Total Belgium	Total/100.000 population
Resi-dential	Full time places	31	43	15	89	0,8
	Part-time (night, WE) places	--	15	--	15	NA
Ambu-latory	places	99	172	111	382	3,6
	users/year(*)	~822	~1428	~921	~3171	~30,2

Table 7.4: NIHDI agreements (Conventions 773) for residential non-hospital services and ambulatory rehabilitation of persons with addiction problems (Source: NIHDI 2009). (*): places x 8,3; extrapolation based on NIHDI study 1999.

Convention 773		Flanders	Brussels	Walloon region	Total Belgium	Total/100.000 population
Resi-dential	Full time places	179	51	139	369	3,5
Ambu-latory	places	334	114	118	556	5,3
	users/year(*)	~2772	~946	~979	~4697	~44,7

7.5.5.3 Day and structured activity

- Day and structured activity, Acute (6)

No information found

- Day and structured activity, Non-acute (7)

To this category belong several types of services; the first is the **Day hospital** (also see Table 4-1). Of the 2383 places for part-time hospitalization in Belgium, less than 1/10th is used for night hospital services. In 2006, 11.562 persons[sss] used day-hospital services, or 110 users/100.000 population/year.

Within the framework of the Belgian federal health insurance (NIHDI) several types of ambulatory rehabilitation centres are established, a few of them addressing persons with a mental disorder, including persons with addiction. Although the main aim of these rehabilitation centres is to provide a temporary service with a specified therapeutic goal, they are mentioned here because some of them function as **Day centres (also named "activity centres")**, providing long-term activities during the day for their target group.

[sss] Source: Federal public service for health, food chain safety and environment, MPG-registration, "Actualisatie van Meerjarenstatistieken van de residentiële geestelijke gezondheidszorg Minimale Psychiatrische Gegevens 1999 – 2003 met MPG2006".

In ambulatory Convention 772 centres (psychosocial rehabilitation), 382 places or 3,6 places/100.000 population or about 30,2 users/100.000 population were available in 2009 (see Table 7.3). In ambulatory Convention 773 centres (addiction problems), another 556 places or 5,3 places/100.000 population or about 44,7 users/100.000 population were available (see Table 7.4).

Some other Day centres are not subsidized by the NIHDI, it is not always clear how exactly they are financed (e.g. "De Link" at Beringen).

In the Walloon region the "centres/services de santé mentale" (SSM) can organize "**Therapeutic clubs**" (Club thérapeutique)[ttt], in which day activities are organized for people with severe or chronic mental disorders. The Walloon region is responsible for funding the largest part of the costs (see further).

Several websites of large care organizations mention that they provide support to persons of their target group that need support to **get (back) to work**. Often they rely on other care providers for this kind of services, e.g. on Public Welfare Centres (CPAS) (Openbaar Centrum voor Maatschappelijk Welzijn (OCMW), Centre Public d'Action Sociale (CPAS)); these centres fall under the responsibility of the local authorities (municipalities).

7.5.5.4 Out-patient and community mental health services (MHS)

- Out-patient and community MHS, Emergency care, mobile (8.1)

Some local experiments exist (e.g. region of Leuven)

- Out-patient and community MHS, Emergency care, non-mobile (8.2)

Centres for crisis intervention for the target group of addicted persons are subsidized by the NIHDI; and Mental health care (MHC) centres (see further) can also provide this service. No separate figures were found.

- Out-patient and community MHS, Continuing care (9)
  - Out-patient and community MHS, continuing care; Mobile (9.1)

Some MHC (see further) experiment with outreach teams. A few teams providing **outreach** to drug addicted persons (street workers) whether homeless or not, are subsidized by the NIHDI. Several Public Welfare Centres (CPAS) or centres supported by the provinces also provide help to drug users, including outreach.

  - Out-patient and community MHS, continuing care; Non-mobile (9.2)

The **mental health care centers (MHC)** (**centres ou services de santé mentale**[uuu] – **centra voor geestelijke gezondheidszorg**[vvv])[www] provide ambulatory diagnostic evaluation and treatment, and provide a follow-up of all the persons leaving residential institutions. They aim at a maximal reinsertion of persons with a mental disorder into the society. To some extent there is a specialization by target group (addiction problems, suicide prevention,…).

The MHC belong to the responsibility of the regional Governments, who can organize such centres in a perfect autonomy. Each region can decide, by a specific 'decree', on the mission of the centre, and on the necessary conditions to receive an accreditation or to be subsidized. In the different regions, the functioning of the centres is based on a multidisciplinary team directed by a specialist in (neuro)-psychiatry. The personnel of the centres is almost entirely remunerated by the regions. Additional activities under the federal reimbursement system (NIHDI) are possible, but should remain limited. The patients pay a very small out-of-pocket contribution for each contact with the centre.

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ttt http://www.iwsm.be/institut-wallon-sante-mentale.php?idt=26

uuu Walloon decree 4th April 1986 and M.B 23rd May 1996

vvv Dutch decree 18th May 1999 and M.B. 17th September 1999

www For centers in Brussels depending on the COCOF : decree 27th April 1995 and M.B. 03rd October 1995 and centers depending on the COCOM : ordonance 17th July 1997 and M.B. 22nd October 1997

The mission of the Flemish "centra voor geestelijke gezondheidszorg" (CGGZ) is to offer adequate care to persons with psychic problems, taking into account the mental equilibrium of the person and the capacity of the social environment of the patient. The CGGZ is a second line organization; it has to give priority to persons with severe and/or persistent problems, persons who have financial and/or social problems, children, and elderly people. The CGGZ coordinates its actions with the first line and the welfare institutions; it is also responsible for preventive actions. The CGGZ is responsible for a geographic area containing minimum 400 000 inhabitants (maximum 26 centres in Flanders (each centre can have different locations), and 2 in the Flemish speaking part of the Brussels region). In 2008, 864 FTE professionals were at work in the CGGZ[xxx], the largest part psychologists (247 FTE). This can be explained by the fact that psychologists in Belgium are not reimbursed in the federal health insurance system (NIHDI). In 2009, 34.967 adults and 3786 elderly persons used the CGGZ[yyy], or 635 adult persons /100.000 population. Taking into account youth (<18 years), a total of 52.072 persons used the CGGZ, or 853,6 users/100.000 population.

In Brussels, The COCOF (Commission Communautaire Française) and the COCOM (Commission Communautaire Commune; i.e. Flemish and French) also organize this type of centres. Twenty-seven centres are recognized by the COCOF[zzz] and five by the COCOM[aaaa].

In the Walloon region the "centres/services de santé mentale" (SSM) provide a diagnostic evaluation and organize ambulatory psychiatric, psychological, social and administrative treatment and help to all persons in need of such help. One mental health service has to cover 50 000 inhabitants; in 2009 there are 61 SSM with 91 different locations in the Walloon region, in which 420 FTE[bbbb] professionals work. The Walloon SSM can also organize "Therapeutic clubs" (Club thérapeutique)[cccc], in which day activities are organized for people with severe or chronic mental disorders (see Day and structured activity, Non-acute).

Within the framework of the Belgian federal health insurance (NIHDI) **rehabilitation centres** for persons with a mental disorder are established. These centres provide multidisciplinary ambulatory treatment during a few hours /week, especially in the field of increasing specific abilities such as social abilities, autonomy to live independently etc. Participants pay a very small out-of-pocket contribution for each contact with the centre.

In ambulatory **Centres for medico-social care** multidisciplinary teams focus on drug related problems offering medical and social support, some of them supplying clean injection needles or substitution products (methadone). These centres are reimbursed by the NIHDI and services are free of charge to the patient. Several Public Welfare Centres (CPAS) or centres supported by the provinces also provide help to drug users. There is a special coordinating service for drug abuse at the Federal public service for health, food chain safety and environment; prevention is under the responsibility of the the regional Governments.

Post cure care: after a stay in general or psychiatric hospitals, a patient can receive a multidisciplinary support at home by a mobile team, or in the hospital, during 3 months.

Ambulatory care givers (general practitioners, psychiatrists, psychotherapists) provide medical services and/or psychotherapy in an ambulatory context. Only the consultations of psychiatrists and general practitioners are partly reimbursed by the health care insurance (not psychotherapists). More detailed analysis of the Belgian databases to find information on the number of patients that consulted psychiatrists in a certain year did not belong to the scope of this report.

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xxx http://www.zorg-en-gezondheid.be/

yyy http://www.zorg-en-gezondheid.be/

zzz http://www.cocof.irisnet.be/site/fr

aaaa http://www.riziv.be/

bbbb Full time equivalent

cccc http://www.iwsm.be/institut-wallon-sante-mentale.php?idt=26

A recent evolution of the nomenclature has created specific acts for psychiatric nurses in charge of controlling the compliance of the patients with respect to the prescribed treatments.

Among the "mixed" services for ill or handicapped persons not in charge of a hospital anymore, a coordinating service for care at home exists, funded by the NIHDI: the **GDT (Geïntegreerde dienst voor thuisverzorging) or SISD (Services intégrés de soins à domicile).** This service is open to all types of disorders, and also to persons with mental disorders. The participation of a general practitioner at the multidisciplinary concertation is obligatory.

In the Walloon region and the French-speaking and bilingual part of Brussels, there exists a service aiming to organize and coordinate all types of care and help that someone suffering from any disease or handicap needs at home, called "**Centre de coordination de soins et de services à domicile**" Although this "mixed service" is often used for elderly persons it is, by decree, open to all ill or handicapped persons in need of professional help at home.

7.5.5.5 Self-help and non-professional mental health services (10)

Beside the full mental health services and care supply organized by the different authority levels (federal, community and region), there exist several non-professional initiatives developed to support persons with a mental disorder and their family. Some initiatives want to gather the persons with a mental disorder themselves, other aim to gather volunteers who take care of these persons. Some of them are subsidized by the regional Governments, and a few also receive subsidies by the Federal public service for health, food chain safety and environment. Some of the most important self-help and non-professional mental health services are mentioned below.

Federal organizations

Similes[dddd] is a Belgian association for all persons with a mental disorder (home, hospital, different mental care settings) and their family. Besides providing support, it defends the interests of the patients against the authorities or against practitioners. Among other specific self-help groups, there exists a Belgian self-help group for persons suffering from Gilles de la Tourette Syndrome, etc.

Flemish organizations[eeee]

These organizations are active on the Flemish territory and in Brussels.

Several self-help groups are specific for persons with a mental disorder. Among others, the organization Ups & Downs[ffff] is an association for manic-depressive patients and their family. The patient association UilenSpiegel[gggg] collects testimonies of psychotic and schizophrenic patients. The Sarah movement is an independent organization open to persons with mental disorders confronted with psychosocial problems[hhhh]. "Zit Stil" and "Aandacht" [iiii] are self-help groups for persons with ADHD (attention deficit and hyperactivity disorder) and their family.

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dddd See http://www.similes.org/ (Similes means 'similar', the name of the association shows that their members refuse the distinction between 'normal' people and mental patients.

eeee See http://www.ggz-overleg.be/content/ggz/site/5608

ffff See http://www.upsendowns.be/

gggg See http://www.uilenspiegel.net/

hhhh See http://www.sarahbeweging.net/

iiii http://www.adhd-volwassenen.be/index.php?option=com_frontpage&Itemid=1

In the Flemish region, there are about different 1 250 'zelfhulpgroepen'[iiii], support groups organized by patients suffering from all types of diseases which try to ameliorate their welfare by organizing contacts and activities among each other. They are supported by "Trefpunt Zelfhulp", an information and education platform subsidized by the Flemish Government and the University of Leuven. Eighty-nine of these patient organizations are regrouped in a Flemish patient platform (Vlaams patiëntenplatform)[kkkk], which defends the rights and interests of patients. It is also subsidized by the Flemish Government. Although its activities are not specifically oriented to persons with a mental disorder, the scope of their actions is large enough to cover psychiatric and psychological problems. This is also true for the Flemish Knowledge center for volunteer aid (Vlaams Kenniscentrum mantelzorg)[llll]

French organizations

These organizations are active on the French territory and in Brussels.

Luss[mmmm] (Ligue des Usagers des Services de Santé) is a federation of the more than 200 self-help groups and patient organizations existing in Wallonia. Luss aims at informing them and defending their rights and interests. It is subsidized by the Walloon region.

Psytoyens[nnnn] is a Wallonian federation of self-help organizations for persons with a mental disorder. Specific French-speaking organizations for persons with mental disorders are, among others, Possible[oooo] and Reflexions[pppp] which are self-help groups for persons with psychotic disorders and schizophrenia. Funambule[qqqq] is a self-help group for persons with bipolar disorder and their family. La Graine (see website Psytoyens) is a self-help group for all persons with psychological or psychiatric problems. Pasifou (see website Psytoyens) is also a self-help group for all persons with psychological or psychiatric problems, situated in the Brussels region.

iiii See http://www.zelfhulp.be/
kkkk See http://www.vlaamspatientenplatform.be/www/index.php
llll See http://www.kenniscentrummantelzorg.be/
mmmm http://www.luss.be/
nnnn http://www.psytoyens.be/
oooo http://www.schizopossible.be/
pppp http://www.asblreflexions.be/
qqqq http://www.funambuleinfo.be/

7.6 FINANCING OF THE MENTAL HEALTH CARE SECTOR

7.6.1 Global data

In Belgium, 6% of the total health budget of the country is spent on mental health (Mental health atlas, WHO, 2005)[rrrr]

7.6.2 Approach per sector of activities

In the following Table, the financing source is mentioned following the ESMS tree if the data are available.

Table 1: Description of the financing of the different mental health (pure and mixed) institutions and teams

Services or institutions	Financing
Full time hospital care	Social security for the fee per day (prix de journée – verpleegdagprijs) and a personal intervention per day for the patient in function of his social status
Part-time hospital care	Same financing as for full time hospital care
Mental health centers (MHC)	In the 'centres de santé mentale', the patients have to pay an amount out-of-pocket (limited) corresponding to the received service. The consultations are free of charge for patients who do not have sufficient financial resources. A lump sum personal intervention can be asked to the patient at the moment of the registration (no charge for the impecunious patient) The MHC can charge the patient for non medical services.[ssss] The region gives subsides to the MHC to cover the personnel expenditures, the functioning costs and the costs for the first installation.[tttt] The centra voor geestelijke gezondheidszorg receives subsidies from the region. The 'centre de santé mentale' organized by the COCOF receives subsides to cover the remuneration of the personal, the general costs and the variables costs. Each centre receive a provisional budget which is a maximum subside. The patients have to pay an intervention corresponding to the received service or medical act. The consultations are free of charge for impecunious patients. The financing and payment conditions of the centres organized by the COCOM are similar to those organized by the COCOF.
Post cure care	Same financing as for hospital care
Rehabilitation centers	- a yearly budget depending on the maximal number of services that can be supplied is determined per centre and divided by the number of acts. The result leads to a daily lump sum ("forfeit") paid by the NIHDI - services reimbursed by NIHDI, small out-of-pocket payment for patient
Psychiatric nursing home (PNH)	- all the medical acts and services (nurses,

rrrr http://www.who.int/mental_health/evidence/mhatlas05/en/index.html

ssss See decree of 4th April 1996, chapter V

tttt See decree of 4th April 1996, chapter VII

	physiotherapists, rehabilitation, manual therapists, speech therapists, medical supervision of a specialist in psychiatry or neuropsychiatry) executed in a PNH are covered by an intervention of the sickness fund (mutuality) - the patient pays an individual intervention equal to the price for the housing (fixed by the Minister) reduced by the subsidy of State and the intervention of the sickness fund - the patient pays also a daily lump sum (0.95 Euro) to cover the co-payment for reimbursed and not reimbursed drugs - the PNH receives a daily intervention of the sickness fund for maximum 48 days off (holyday) to promote the social reintegration of the patient
Initiatives of sheltered living[uuuu] (ISL)	A yearly budget is allocated to each ISL, this lump sum is composed by : - a unique allocation for the installation of the ISL - a amount per place for personal costs - a fixed amount per ISL for the registration of the Minimum Psychiatric Summary (Résumé Psychiatrique Minimum) augmented by a fixed amount per place - a fixed amount for the medical function depending on the number of places - a fixed amount (paid until 2005) for the salary increase in function of the number of experience years - a fixed amount for the organization of daily activities depending on the number of places (the financed number of FTE is function of the number of places) - a yearly financial compensation for the measures of career's end - the ISL cannot ask a supplement to the patient or to the mutuality[vvvv]

7.7 SPECIFIC PROBLEMS OF THE BELGIAN MENTAL HEALTH ORGANIZATION

- The large part of the Belgian psychiatric cure but also care (e.g. PNH, ISL), belongs to the domain of the federal Government, and more precisely the NIHDI. This is remarkable, since this kind of initiatives for other types of disabled persons, e.g. mentally retarded or physically handicapped persons, belongs to the responsibility of the regional governments (VAPH or Vlaams agentschap voor personen met een handicap; AWIPH or Agence wallonne pour l'intégration des personnes handicapées; DPB or Dienstelle für Personen mit Behinderung; Brussels COCOF. Probably this situation is the consequence of the reconversion operations that took place in the nineties and the first years of this century. This does not mean that the services provided for persons with mental disorders are inappropriate, but one should be careful because the NIHDI does not have the same experiences and background in the organization of services meant for life-long care and support.

uuuu A.R. 18th July 2001 (MB 26th September 2001) modified by A.R. 29th September 2002 (MB 07th November 2002), A.R. 10th March 2003 (MB 02nd April 2003) and A.R. 13th March 2003 (MB 20th March 2006)

- One group of persons with a mental disorder however, fall under the responsibility of regional governments: persons with autism-spectrum-disorders, probably because they are considered to be "developmental disorders" and because their signs and symptoms become clear early in life. A group for which it is less clear where they can find long-term care, is the group of persons with Acquired brain injuries.
- Psychiatric cure (diagnosis and treatment) is still mainly concentrated in « Psychiatric hospitals » (4686 A-beds) rather than in psychiatric departments of general hospitals (2404 A-beds).
- For PNH and ISL, the norms decided on by law are not yet reached. Yet there are long waiting lists to enter. New initiatives might be necessary to fill the gap.
- For day activities of those persons living in ISL or on their own, but not capable of working any more, the « day hospitals » are probably too much oriented towards treatment. There exist some day centers (activity centers) reimbursed by the NIHDI, are these initiatives sufficient for the target population ?
- Specific structurally reimbursed services for this population to support work rehabilitation (supported reinsertion into work) were not found, do they exist ? Can this population rely on general initiatives, e.g. by Public Welfare Centres (CPAS) or general federal initiatives (VDAB etc)?
- Concerning the third reformation wave, some coordination functions are already structurally implemented and reimbursed : the Concertation platforms, the « Institut Wallon de santé mentale », and recently the Walloon « Centres de référence de santé mental » for coordination of SSM and ambulatory mental health care. It might be useful to delineate more into detail the actions of these different initiatives, to prevent overlap. To improve the working, and to evaluate the strong and weak point of this type of initiatives, it might be useful to install external evaluations, e.g. every 5 years.
- Initiatives for patient centred coordination still only exist on a temporay basis (the different types of Projects), and still have to prove their added value. Once installed, a system of evaluation of their working should also be foreseen.
- For the Psychiatric hospitals, Psychiatric departments of general hospitals, PNH and ISL, data registration is obligatory (the MPD). The Belgian MPD are very extensive, and include a lot of information, e.g. not only on psychiatric diagnosis but also on functioning of the included persons. It is worthwhile to analyze these data and publish this kind of studies.

8 FRANCE

8.1 LITERATURE SEARCH: METHODOLOGY

Search on the web (Google and OAister) (search terms: 'Organisation of psychiatry in France', 'Financing of psychiatry in France', 'Mental health organisation in France', 'Mental health financing in France'), search on sites of DREES (Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques) IRDES (Institut de Recherches et de Documentation en Economie de la Santé), French Health Ministry, WHO (World Health Organisation), OECD (Organisation for Economic and Cooperation and Development), CNAMTS (Caisse Nationale d'assurance Maladie des Travailleurs Salariés), INED (Institut National d'Etudes Démographiques), INSEE, UNCPSY (Union Nationale des Cliniques Psychiatriques privées), Social Security, HAS (Haute Autorité de la Santé), MNASM (Mission Nationale d'Appui en santé Mentale - http://www.mnasm.com/), specific web addresses : http://www.annuairesante.com ; http://www.cadredesante.com ; http://legifrance.gouv.fr ; http://archives.handicap.gouv.fr; http://www.anaes.fr ;Direction Générale de l'Action Sociale (DGAS) http://www.serpsy.org;http://www.cohesionsociale.gouv.fr/; Haute Autorité de lutte contre les Discriminations et pour l'Egalité http://www.halde.fr.

No information (references, data…) has been included after August 31, 2009.

8.2 ORGANIZATION AND FINANCING OF THE HEALTH CARE SECTOR: SOME ASPECTS

In 2007, France had 63,6 million inhabitants[wwww]. We can distinguish[xxxx] two kinds of health care costs covering: the **statutory insurance system**, composed by four different schemes (employees and their families – self-employed workers – agricultural workers and their families – others), and the **complementary insurance system**, divided into three types of institutions (mutualities – private companies – provident societies).

8.2.1 The statutory insurance system

Each year since 1996, the parliament passed an Act on Social Security Funding (LFSS)[yyyy] based on the reports of the Accounts commission (Cour des Comptes) and the National Health conference. This act sets, among other things, a projected target for health insurance spending for the following year known as the national ceiling for health insurance expenditure (ONDAM)[zzzz]. This global target is composed by four specific budgets for the public hospital sector, the private hospital sector, the ambulatory care (soins de ville) and the medical – social institutions.

Table 8.1: Composition of the National budget for health care in 2007

ONDAM 2006	Mil €	% of total budget	% of the GDP
Ambulatory cares	66,7	47,3%	3,7%
Total hospital cares	63,4	44,9%	3,5%
Medical - social institutions	11,0	7,8%	0,6%
Total	141,1	100,0%	7,9%
GDP	1 792,0		

Source: Report on Social Security [182] and INSEE

wwww http://www.insee.fr/fr/themes/tableau.asp?reg_id=0&ref_id=NATnon02151

xxxx We base this section on three main sources Sauvignet 2004 [180] and Sandier et al, 2004 [181] and the reports of the Social security (Comptes de la sécurité sociale). We use different official sources of data to compute proportion of beneficiaries and the composition of the financing.

yyyy LFSS for Loi de Financement de la Sécurité Sociale

zzzz ONDAM for 'Objectif National des Dépenses de l'Assurance Maladie'

The statutory health insurance system is divided into three main health insurance schemes and a set of 12 special schemes for certain categories of the population.

8.2.1.1 The general scheme

The general scheme originally included 129 (*this figure is currently being cut down, because of ongoing restructuring*) local funds (CPAM)[aaaaa] to affiliate members and reimburse the major part of the cost paid by the patients, 16 regional funds and a national fund (CNAMTS)[bbbbb]. About 81 % of the total population is covered by this scheme.[ccccc]

Table 8.2: Breakdown of the financing of the general scheme in 2007

General scheme	Billions €	% of the total
Contributions	65,0	51,0%
CSG	49,0	38,4%
Taxes	13,5	10,6%
Total	127,5	100,0%
% of the total population	81,2%	

Source: Les comptes de la sécurité sociale – Septembre 2007 – INED (Institut National d'Etudes Démographiques)

8.2.1.2 The other schemes

Two other schemes – the self-employed scheme and the farmers and agricultural employees scheme cover respectively 5% and 7% of the population. Other smaller schemes, generally based on professional specificities and set up for historical reasons still cover approximately 7% of the population (all together).

8.2.2 The complementary insurance system

The complementary coverage is provided by three types of OCAM[ddddd] organizations: the mutual insurance associations, the private for-profit insurance companies and the provident institutions. We distinguish 740 OCAM composed by 550 mutualities, 130 private insurers and 60 provident institutions. In 2002, 86 % of the population was covered by a complementary insurance and if we take the CMU – C into account (free-complementary coverage for underprivileged people), the covering concerned 91 % of the population[180].

8.2.3 The financing of the hospital sector

Since 2006, all the public and private health institutions, earlier financed by a global budget[eeeee], have to present an estimated state of incomes and expenses. This new budget system is linked[182, 183] with the new system of price fixing (T2A)[fffff] .To implement this new system of price fixing, homogeneous groups of patients are required to compute predicted costs per group. Nevertheless, the determination of such costs is more difficult to implement for care such as psychiatry. That is the reason why the psychiatric institutions are yet financed by a global budget, waiting for a validation of a T2A modelling.

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aaaaa CPAM for Caisses Primaires d'Assurance Maladie

bbbbb CNAMTS for Caisse Nationale d'Assurance Maladie des Travailleurs Salariés

ccccc We computed the proportion of beneficiaries using the total population (61 538 thousand in 2007). This means that the denominator of the proportion contains the total number of state employees (4 % of the total population) and the total number of the beneficiaries of the three main insurance schemes and the twelve special schemes.

ddddd OCAM for Organismes d'Assurance Maladie Complémentaires (Complementary Health Care Insurance Institutions)

eeeee Dotation globale

fffff T2A = Tarification à l'activité

8.2.4 The French health care system: which problems?

8.2.4.1 A lack of coordination and continuity of care.

In spite of its advantages (especially freedom of choice for patients and a relatively high average density of health care supply, at least in most populated areas), the main weaknesses of the French system remain the lack of coordination and continuity of care provided by often isolated professionals, as underlined by the HIT report issued in 2004[184]. This is not specific to ambulatory medicine (GP and specialized doctors alike) but also to the interface between the ambulatory sector and the hospital sector. In practice information sharing and more generally coordination between both sectors remain poor and problematic.

This trait of the French system is specifically penalizing for chronic patients, who require a long-lasting medical follow-up over several years (or even a lifelong follow-up). As a matter of example, a national survey conducted on diabetes showed that only 40% of diabetic patients have an eye examination yearly (in line with the official guidelines on diabetes). This kind of statement can be applied to chronic diseases in general, including psychiatric ones.

8.2.4.2 Networks and the GP gate-keeper system: solution or not?

Since the nineties, health authorities have set up reforms and innovative projects to tackle this problem and to try to bridge the gap between both sectors (and more generally to improve coordination of care and patient-centred approach).

1. On a purely voluntary basis health care networks have been implemented at a local level since 1996 and supported by the National Health Insurance Funds. These networks were set up with a view to improving coordination of care and avoiding redundant exams and/or waste of working time, especially for chronic diseases. However, these networks have reached their limits: they are based on purely voluntary basis and this kind of health-care organization is not the norm (legally speaking).
2. GP-steered gate-keeper systems.
    a. The first system – called "Médecin Référent" (litt. Referring Physician) was set up on a purely voluntary basis. Few GPs joint this system (ca 10%), and eventually it did not prove very efficient on the long term.
    b. The second system – called "Médecin Traitant" (litt. Treating Physician) was organized on a compulsory and regulatory basis (Health Care Modernization Act 13 August 2004). All patients are required to chose a GP as gate-keeper to enjoy normal rate of reimbursement. However this system is partly by-passed in the field of psychiatric care: direct access to psychiatric care specialists is allowed for patients below 25. Conversely, as shown below, referral to secondary care is not always well organized, basically because of supply shortage in many regions.

8.2.5 Impact of quality assessment in the French health care system.

The French National Authority for Health (HAS or Haute Autorité de Santé) was set up by the French government in August 2004[ggggg] in order to bring together under a single umbrella a wide range of activities designed to improve the quality of patient care and to guarantee equity within the healthcare system. Therefore, activities of the HAS range from publication of guidelines to accreditation of healthcare organisations and certification of doctors.

In France, quality control is broken down into 3 different proceedings:

Certification process *for health care establishments* [hhhhh] (since 2004 the word Certification has superseded the word "accreditation" for health care establishments)

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ggggg http://www.has-sante.fr/portail/plugins/ModuleXitiKLEE/types/FileDocument/doXiti.jsp?id=c_885249

hhhhh http://www.has-sante.fr/portail/

***Evaluation** of Professional Practices (EPP)*

In the very last version of the accreditation manual (2010 Version), specific criteria in the domain of EPP are defined that apply to psychiatric practice – Criteria 19c "*Suicidal risk*" and Criteria 19 d "*Hospitalization without consent*" (patients sectioned pursuant to the French legislation – Act dated 27 June 1990 modified by Psychiatric patients' rights of 4 March 2002).

***Accreditation** of doctors for "at-risk specialities"*. However, psychiatry is not concerned by this latter type of quality control.

The final decision of the HAS is completed by a specific list of follow-up decisions, designed to ensure a concrete implementation of improvement measures. However, we must bear in mind that :

- There is no individual "grading" of doctors, health professionals, or hospitals
- There is no direct connection between the accreditation process and funding channels (responsibility of the Regional Hospital Agency). Further administrative decisions can be made against hospital experiencing major problems, but this remains within the remit of the Regional Hospital Agency only.
- This accreditation process is mainly focused on a cross-functional approach, work processes, safety measures and not on quality of medical acts individually.

Key points

- **The French health care system remains problematic in terms of coordination of care, interface between primary and secondary care and more generally continuity and follow-up.**
- **The French quality assessment system has not been designed as a cost/efficiency measurement framework.**

8.3 THE MEDICAL SOCIAL SECTOR IN FRANCE

We mention some characteristics of this sector because it finances a part of actions considering persons experiencing problems caused by the lack of autonomy. After the heat wave of august 2003, the authorities decide to organize a central response to the specific problems caused by the lack of autonomy. The Caisse nationale de solidarité pour l'autonomie (CNSA) was created by the law N°2004-626, 30th june 2004. One of its missions is the repartition of the credits defined by the ONDAM and destined to the old dependent people and the handicapped persons. The CNSA received its first complete budget in 2006 and since, the 'objectif global des dépenses' (Global budget for the expenses) is the combination of two principal sources: the credits of the medico-social ONDAM and the own revenues of the CNSA.

Table 8.3: Revenues of the Caisse Nationale de Solidarité pour l'Autonomie (CNSA) (Total 16,2 Milliard euros) – Budget 2008

Own revenues	Credits from the health insurance (medico-social ONDAM)
Contribution Solidarité Autonomie : 2,289 Contribution Sociale Généralisée : 1,095 Participation 'retirement system' : 0,065	Health insurance old and handicapped persons : 12,781

Source: Budget 2005 and 2006 of the CNSA[185] and Budget of Social security [182, 183]

8.4 ORGANIZATION OF THE MENTAL HEALTH CARE SECTOR IN FRANCE

We focus our analysis on the general psychiatry for adults. This means that we do not take into account neither child and adolescent psychiatry nor forensic psychiatry.

8.4.1 Historical background[iiiii]

It is common knowledge that the history of the mental health in France is linked to the movement of the ideas and realizations in the rest of the world. But we only sketch here the most important moments of the French history. We begin this history in 1802 with the permanent closure of the 'salles de fous ou de folie' and the creation of the lunatic asylum (asiles d'aliénés) where the mental patients were taken in charge by an alienist. The law of June 30th 1838 remained the institutional framework for the management of mental patients during 150 years. This law organizes the hospitalization in the public and private institutions, the protection of the sick persons and of theirs goods. The principal aims of this law were the organization of asylum, the protection of the population and the regulation of the compulsory admission. In 1922, the creation of the first open hospital by Doctor Rousselle is the first step of the transformation of the asylum into a hospital. By the decree (circulaires) of October 13th 1937 and September 2nd 1946, the lunatic asylum becomes the psychiatric hospital.

Since the sixties, key trends of organization of mental health policy have been the following:

- From a **clinical point of view,** "de-institutionalization": patient management outside hospital environment as long as the patient's condition enables it, with a view to safeguarding his dignity. This policy was largely inspired by WHO recommendations.
- From an **administrative point of view:** a long-term "sectorization" policy, ie. a division of the territory into "sectors" (health care supply areas), with a view to cover a specific part of the population and to set up multidisciplinary teams providing preventive care, acute treatment and follow-up. At the present time, the French territory is divided into ca **800 sectors** (general psychiatric care/ patients above 20 years of age).

Following Lucien Bonnafé[jjjjj], the official birth of the sectorization is the colloquium of Sèvres in 1958 organized by the céméa[kkkkk]. The decrees (Circulaires) of March 15th 1960 and March 14th 1972 give the legal base of this radical transformation of the mental health care, which should make the mental health sector evolve from a 'hospital-centrism' to an open and community system.

However, the basic principles of the French mental health care "sectorization" policy are somewhat different from the basic organizational principles in many other countries, and specific traits of the French policy have been identified as below:

- It did not involve the closure of a large number of psychiatric hospitals (like in the UK or in Italy) because a comprehensive patient management including hospital and ambulatory care has been deliberately favoured.
- Efforts have been made to anchor the initial step of the patient pathway and patient management as close to his place of residence as possible.

In short, from the beginning onwards, the "sectorization" has never been considered to be an alternative to the hospital; it has been considered to be a complementary activity. Whether this has been realized or not, will be discussed below.

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iiiii We based this historic part on http://www.ch-charcot56.fr/histoire/histpsy/7cadregl.htm, http://psychiatrie.histoire.free.fr/index.htm, http://www.serpsy.org/histoire/histoire_index.html, Chapireau, 2007, pp. 127-143 [186]

jjjjj French Psychiatrist 1912 – 2003. He has initiated and participated to the sectorization in France

kkkkk Céméa : centres d'entraînement aux methods d'éducation active

The law of December 31st 1985 legalizes the fusion of the hospitalization expenses with the sector expenses and reinforces the decree (Circulaire) of 1960. The decree (Décret) of March 14th 1986 defines the technical organization, the nature and the responsibility of the public institutions of care, making the difference between institutions with and without residential possibilities. The evolution of the deinstitutionalization has also to be analyzed taking into account the development of elderly care and care for handicapped persons, the development of the social assistance and, partially, the development of the drugs for mental problems.

8.4.2 General principles – the sectorization

The sector is based on a multidisciplinary team and different possibilities of residential and ambulatory, medical and social services. Each sector is responsible for the accessibility and the continuity of the care for every patient in each stage of the development of the disease. The organization of psychiatry and mental health care is defined by the SROS[lllll] (Schéma Régional d'Organisation Sanitaire – Regional Scheme of Sanitary Organization). The regional scheme of the psychiatric hospital organization is defined by the Regional Agency for hospitalization (*ARH – Agence Régionale d'hospitalisation*).

Of all patients treated in 2003 in the "sectorized" psychiatry 0,5% were children (<16 yrs), 82,7% were adults (16-64 years) and 16,8% were elderly (65 years and older) (Coldefy 2007 p28)[187-189].

8.4.2.1 Sector: multidisciplinary team responsible for continuity of care

The public adult mental health services are organized according to specific catchment areas, the 'sectors'. The sector is based on a multidisciplinary team (at least one), working in a medico-psychological centre (CMP – Centre Médico-Psychologique) that is attached to a residential institution. In 2000, there were 2200 CMPs in France[190]. As a consequence of fusions and the development of inter-sector activities (see further), there were 2070 CMPs in 2003 (Coldefy 2007)[187-189]. The CMP is in charge of patient care, continuity and coordination of mental care and social support. The team of the CMP is composed by physicians, psychologists, nurses, social assistants, qualified educators, paramedical personal like psychomotor therapists, manual therapists etc. The goals of this way of organization are to promote the development of prevention and community care and to assure the access to mental health care for everyone living in France[190] but also to make psychiatry evolve outside the hospital[191].

In 2003, we found 817[mmmmm] sectors in France, each covering, in average, 59 000 inhabitants aged 16 years or older (with a range between 33 and 133 000[nnnnn])[187-189]. This sectorization results from the 'Plan for catchment areas' adopted in 1960 and fully implemented from 1975. In 1975, there was one sector for roughly 70 000 inhabitants[191]. This number has been derived from the WHO norms recommending 3 beds for 1 000 inhabitants in services of maximum 200 beds[187-189]. The geographic area of a sector is not the same in urban and rural zones, and the residential institution to which the CMP is attached, is not always situated in the geographic zone of the sector. This particularity means that the larger distance between a community and the attached hospital can strongly vary from one sector to another sector (average distance 45 kilometres and 63 kilometres for a quarter of the sectors)[187-189].

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lllll The SROS is based on the real needs and activities of a region. The determination of a SROS takes epidemiological characteristics of the region into account.

mmmmm Coldefy mentions 60 700 inhabitants per sector[187-189]. Verdoux 2007 mentions 839 catchments[190] and Provost & Bauer, 829.[191] Other documents cite 830 sectors but some sectors were not implemented and some were merged[192]

nnnnn Chaleix 2006 (p.68), proposes another figures: 56 100 inhabitants aged 20 years[193].

In 2003, the multidisciplinary teams have seen approximately an average of 1 500 patients treated by medical (6.5 FTE) and non-medical (78.2 FTE) personnel[187-189]. For the same year, we find 55 % of the sectors attached to a public health institution specialized in psychiatry (former specialized hospital centres), 37% attached to a non specialized public health institution (hospital centre or regional hospital centre) and 8% attached to a private specialized health institution.

8.4.2.2 General organization of the hospital activities

The distribution of residential beds is clearly uneven throughout the country[191] (see also paragraph 8.4.3.3). Moreover, a low density of beds is not necessarily compensated by a high density of places (i.e. partial hospitalization during day or night only). The number of adult beds available in 2004 was about 56.700, or 91.4 per 100.000 inhabitants[193] but with a wide range, depending on the area[190]. The number of adult partial hospitalization places equalled 17.666, or about 28.5 per 100.000 inhabitants[193]. In 2000, two thirds of all the available beds were located in mental hospitals, one third in general hospitals[190]. Also the repartition of psychiatrists is very uneven (see 8.4.3.3 and Appendix); in 2004 there were on average 23 psychiatrists for 100 000 inhabitants, but with a large difference between sectors and departments[190].

From a point of view of financing, we can distinguish two budgeting systems. First, the system of projected budget (budget prévisionnel) applied to the public institutions and the private institutions which have chosen the same price fixing system as the public institutions (system of global budget). Second, the OQN (Objectif Quantifié National) or National Quantified Goal applied to the pure private institutions. In the first category, we find the CHS (Centres Hospitaliers Publics Spécialisés en Psychiatrie), the SPHG (Services de Psychiatrie des Hôpitaux Généraux Publics) and the HPP (Hôpitaux Psychiatriques Privés Faisant Fonction Publics). As shown in Table 8.4, the 'pure' public institutions represented in 2004 2/3 of the beds and 4/5 of the places[ooooo]. Taking the private institutions under global budget into account, the 'public' sector represents 80 % of the beds and 98,5 % the places in 2004. The second category is composed by pure private institutions or clinics, and post-cure houses.[194] [195]. To further complicate the matter, whereas the system of geographical "sectorisation" is specifically meant to organize psychiatric care, some public general hospitals and most but not all private specialized hospitals also provide hospital services to persons with mental disorders (Coldefy 2007 p 61) outside this "sectorized" system (see Table 8.4).

Table 8.4: Number of beds (hospitalization) and places (partial hospitalization) in the sectorized and not sectorized psychiatry for adults in France (situation on 31 December 2004)

Adult psychiatry	Public institutions		Private institutions financed by global budget		Private institutions outside global budget		Total of the institutions	
	Beds	Places	Beds	Places	Beds	Places	Beds	Places
Sectorized	37.718	14.104	5.354	1.728	0	0	43.072	15.832
Not sectorized	1.022	302	1.544	1.310	11.081	222	13.647	1.834
Total	38.740	14.406	6.898	3.038	11.081	222	56.719	17.666

Source : Chaleix 2006 p. 65 [193]

ooooo We use the concept of 'bed' for complete hospitalisation and 'place' for partial hospitalisation (night or day)

8.4.2.3 The development of 'inter-sectoriality'

The common pooling of means and personnel between sectors becomes more and more necessary to meet specific problems of psychiatric patients. These collaborations can take two forms: a non-formalized inter-sector collaboration where one physician is responsible for the delivery of acts for several sectors (in 36% of the sectors in 2003). The formalized collaboration is organized by the means of an autonomous team which delivers services for several sectors (50% of the sectors in 2003 with an average of 2 or 3 teams per sector) (Coldefy, 2007, pp; 41-44[187-189]).

8.4.3 Evolution of the French policy from 2003 onwards

8.4.3.1 The Cléry-Mélin Report

In **2003**, the **Clery-Melin Report**, titled "*Action plan for development of psychiatry and promotion of mental health in France*"[196] became a key milestone for decision-makers. This report outlined the many pitfalls and problems encountered by the French mental health care system, and formulated proposals for improvement. The 7 priorities, as identified by this report were the following:

1. Reorganising first line health care supply and raising public's awareness on mental health-related issues
2. Reducing inequality in health care & health care supply
3. Improving child and teenager mental health care
4. Setting up a specific framework for the elderly
5. Recasting of judicial legislation
6. Improving quality assessment and training of health professionals
7. Supporting research activities

8.4.3.2 The Mental Health Plan 2005-2008: Last reform of the sector in France

Following the Clery-Melin report mentioned above, the **Mental Health Plan 2005 – 2008 (1.5 billion €)**[197] was implemented by the Dpt of Health, more precisely, based on the five following priorities [PPPPP]:

- Decompartmentalizing patient management: improving information and prevention, improving coordination between GPs and other professionals, improving geographical distribution of health professionals, and continuity of patient management.
- Better consideration of patients', carers' and health professionals' problems and recruitment plan.
- Providing further support to research and quality assessment activities: building up and sharing knowledge on best practices, improving information on psychiatry.
- Implementing disease-centered and population-focused programs: depression/suicide; judicial programs, youngsters, vulnerable groups.
- Practical follow-up and assessment of the plan.

The **Department of Health** conducted in 2006 an assessment of the situation and underlined the following achievements of the Mental Health Plan for 2005-2008:

- As a whole, a major supplementary financial involvement: **1.5 billion €** as underlined above (which would correspond to 250 mil € for Belgium).
- An **ambitious** extra-**recruitment plan**: 275 specialized doctors, and 2250 paramedics, psychologists, and other professionals. Hence, the number of psychiatrists should be stabilized until 2030.

PPPPP Description of the plan in LOPEZ 2006[198] and three first editions of the 'La Lettre du Plan Psychiatrie et santé mentale'

- An improvement of the **psycho-social care supply.** Notwithstanding this, the situation remains difficult: 20% of psychiatric beds are allocated to patients not in need of hospital care (anymore), but to whom supportive community medico-social care is not available. This is clearly due to the fact that no financial continuity is guaranteed between the upstream clinical process of the patient pathway – ie. the initial clinical dimension of the patient pathway- and the medico-social dimension of the patient management (see also further paragraph 8.5.3.1). This lack of financial continuity is due to the diversity of funding origins. In practice, medico-social care is funded by local authorities, and actual level of funding depends on their actual financial capacity. Therefore, there is no guarantee that this funding meets the patient's needs.
- A new **"population-centred" approach** to focus on the most vulnerable patients (elderly people, youngsters, people subject to suicidal behaviours, etc..).
- Implementing pathology-centred and population-centred approach for the new programs (depression, suicide, elderly people, social outcasts..).
- Fostering decompartmentalizing of patient management: improving coordination of health care suppliers, patient-centred approach, and multi-disciplinary team work.

8.4.3.3 Situation anno 2009: still many drawbacks.

Rapport Couty (Jan 2009)

In January 2009, a survey was issued on the request of the Department of Health, to get a comprehensive view of the mission and the organization of mental health and psychiatric care in France. This survey, also known as "Rapport Couty"[199] made specific suggestions on the following aspects: training, research, and coordination of care at the local level. To realize the latter aspect, the rapport Couty launched an innovative idea: the implementation of Mental health local cooperation groups (Groupement local de coordination). These Groups should bring together all types of professionals in charge of first line mental health care, be it prevention, residential community care, ambulatory care, social care,… but excluding hospitalization. The task of these groups would be to provide all types of care necessary in their region, and to ascertain 24h access to the services. It is worth mentioning that the last reform on health care organization designed by HPST (Hôpital patients santé territories) Act of July 2009 enables new cooperation frameworks and delegation models between health professionals under the control of the HAS. This could also be an opportunity to improve field organization of mental health care.

Rapport Milon (April 2009)

In April 2009, MP Alain Milon issued a new and comprehensive report on the French situation in the field of psychiatric care, including the image of psychiatry and psychiatric care in France: "La psychiatrie en France: de la stigmatisation à la medicine de pointe"[200]. He conducted a survey on current organization and practices and put forward proposals for the forthcoming years. He underlined the drawbacks of the current French system, and the numerous obstacles that patients encounter or experience along their pathway.

The first major problem outlined by Milon, is the persisting problem of **uneven distribution of health care supply** and actual access to health care (already mentioned in the Cléry-Melin Report 2003). Distribution of psychiatric care supply across France is quite comparable to what it is for other medical fields, i.e. an uneven distribution between regions, between urban and rural areas, and between privileged and underprivileged areas. E.g., in 2008 the number of practising psychiatrists was 11 271. Forty-seven % of them was working in the ambulatory sector, and 53 % in hospitals (or clinics), which can be considered as a good balance between both sectors.

However, 5267 psychiatrists or half of the total workforce was located in the Parisian region and in five southern large cities, although their population amount to only 30% of the overall French population (See Appendix). Following the measures of the last Mental Health Plan 2005-2008, the overall number of psychiatrists should be stabilized by 2030, but this will not resolve the problem of distribution itself. The latter problem is unlikely to be solved over the next years, as it also deals with freedom of establishment of physicians in general.

A second point outlined by Milon, is the problem of **the waiting times**, which in most public hospitals can reach several months. This problem has also been mentioned by Coldefy et al[187-189]. Milon cites an in depth survey conducted recently by the French National Authority for Health (Haute Autorité de Santé or HAS), on the issue of waiting times in public hospitals (Psychiatric Departments). This survey has analyzed the consequences of this phenomenon. Indeed, combined with other factors (especially poor distribution of supply across regions) it has far reaching negative consequences for French patients. It has been clearly noted by the HAS that one third of schizophrenic patients, one half of depressed patients, and three quarters of alcohol-addicted patients do not have access to affordable health care in due time. In practice the GP is often in charge of long-term follow-up of chronic patients. According to Milon, a noticeable part of psychotherapeutic tasks and consultations are carried out by psychiatrists, although they are - or at least could be considered as - a matter for psychology (and not psychiatry). However, psychologists are not reimbursed. This problem has been identified in different countries.

A third point, according to Milon, has to do with **training of health professionals**. On the whole health care supply chain, one must outline, that health professionals' actual skills do not always meet the required standards. In that respect the most urgent problems seem to be the following: 1. **GPs**: in spite of their key role in early detection of psychiatric patients as well as in long-term follow-up, GPs' training is not specifically dealing with psychiatric issues; 2. **Nurses**: following a regulatory reform, the degree of psychiatric nurse officially disappeared in 1992 (unlike in other countries). Graduated psychiatric nurses continued to work in public hospitals only and psychiatric nursing care cannot be provided in an ambulatory environment. There is currently a large consensus to solve this regulatory problem and to recreate a specific degree of psychiatric nurse care (Master's degree) over the next years.

The fourth point outlined by Milon, deals with **collaboration issues between professionals**. Due to a lack of fitting structures or regulatory framework, collaboration between professionals – ie GPs and secondary care; nurses and physicians; health professionals and other professionals; ambulatory sector and hospital sector – remain difficult or at least uncertain. As already pointed out in paragraph X.2.4, this holds true not only for the mental health care sector, but throughout the full health care sector. Two possible solutions have been implemented since the nineties to tackle this general problem of lack of coordination and cooperation: 1. health care networks (set up on a purely voluntary basis) are supported by the National Insurance Funds. However, in 2008 only 32 mental health care networks had been established, most of them situated in 15 of the +-800 sectors (Rapport Milon 2009, p68); 2. another type of collaboration between different service providers are "Conventions", or written agreements between a psychiatric sector and e.g. social care providers (Coldefy 2007 p44). However, not much information has been found on practical consequences of these Conventions; 2. a compulsory GP-steered gate-keeper system exists (see also paragraph 8.2.4.2). Nevertheless, these measures seem far from sufficient to improve substantially the situation, which is even more difficult in areas experiencing health care supply deficiency.

The IRDES report (August 2009)

In August 2009, an in-depth and retrospective analysis of the 50-year sectorization policy, carried out by the IRDES "Questions de Santé N. 145 – August 2009", has clearly identified several weaknesses and limits in this field (see also Coldefy 2009)[201].

From a conceptual point of view, sectorization does not involve a uniform mental health policy and a common way of delivering care across the country. This can be justified from a practical point of view. However, it can be difficult in terms of visibility but also quality level.

In terms of full-time and part-time hospital beds, the level of **health care supply remains uneven across regions**, as already discussed in paragraph 8.4.2.2. Likewise, distribution of medical and nursing workforce remains clearly uneven across regions (see also paragraph 8.4.3.1, Cléry-Melin Report; and 8.4.3.3, Rapport Milon) and the problem of discrepancy between some urban and some rural areas has not been solved so far. In other words, the sectorization policy did not always succeed in covering a reliable interface between hospital-centred strategy and ambulatory alternatives. This is clearly illustrated by the results of the survey conducted by the IRDES.

Based on this survey the IRDES has sorted psychiatric sectors by "level of resources"; and geographical dimension, i.e. rural or urban environment has been taken into account. Resources must be understood as the wide range of criteria including: full time and part-time beds, full-time equivalent health professionals, timeslot and accessibility of psychiatric care. As clearly shown on the map in the Appendix, discrepancies exist across regions but also within each region, often without clear explanation, other than historical ones. As already mentioned, patients in some rural areas enjoy rapid access to high-level psychiatric care, whereas others do not.

Key points

- **The recent evolution of the French policy has focused on decompartmentalizing and care coordination, pathology- and population-centred approach, an extra work force recruitment plan and improvement of socio-medical care supply.**
- **However, limits and weaknesses have been identified: long waiting lists exist, actual access to adequate care remains problematic for a noticeable part of patients, distribution of health care supply remains uneven and coordination between primary and secondary care is poor.**

8.4.4 Mapping of existing services: Introduction

We use the 'Service Tree' developed by Johnson et al. to map the mental health services[5]. This 'Tree' distinguishes five main different structures of mental health services: secure, residential, day & structured activity, out-patient & community and self-help & non professional services. The second, third and fourth structures are developed as a tree to take into account the differences between acute and non-acute care, emergency and continuing care but also the duration, the intensity and the mobility of the care or activities.

We present a table of all the existing services applying the ESMS tree and we describe the organizational and financial aspects of each of them in the following sections. We distinguish '**Full mental health services**' which is a matter for the psychiatric sector, from the **Mixed services** ('Residential mixed services' and 'Mixed support teams'). We find 'full mental health services' in all the categories of the Service Tree developed by Johnson but the mixed services are typically residential services and mixed teams are only ambulatory services. Residential mixed health services and mixed support health and social teams concern a broader group of patients or persons knowing social problems. Therefore, we propose three exhaustive lists of services; each list is ordered according to the ESMS tree (the figures in brackets refer to the synthetic Table).

Table: Synthetic presentation of the ESMS tree

SECURE **(1)**			
RESIDENTIAL	Generic acute	Hospital **(2)**	
		Non-hospital **(3)**	
	Non-acute	Hospital **(4)**	Time limited **(4.1)**
			Indefinite stay **(4.2)**
		Non-hospital **(5)**	Time limited **(5.1)**
			Indefinite stay **(5.2)**
DAY & STRUCTURED ACTIVITY	Acute **(6)**		
	Non-acute **(7)**	High intensity **(7.1)**	
		Low intensity **(7.2)**	
OUT-PATIENT & COMMUNITY	Emergency care **(8)**	Mobile **(8.1)**	
		Non-mobile **(8.2)**	
	Continuing care **(9)**	Mobile **(9.1)**	
		Non-mobile **(9.2)**	
SELF-CARE & NON-PROFESSIONAL **(10)**			

8.4.4.1 The 'full mental health' services

We name 'full mental health services' all the services organized in the context of the sectorization of the adult psychiatry. Hospitalization beds (full time) and places (part time) in the non-sectorized psychiatry (see Table 8.4) are also mentioned: they amount to 24% and 10% respectively of the total[193]. We did not find any information on the availability *in the non-sectorized psychiatry* of: residential non-acute non-hospital services, non-hospital services for day and structured activity, or outpatient and community care; so these services might be underestimated.

The evolution of the structures per sector is described in Table 8.5. The CMP are the most representative services in the psychiatric sectors. All the sectors, except 4, have organized a CMP and in 70 % of the cases we find 2 CMP[187-189]. In 2003, there were 817 sectors in France, and 2070 CMP. We will describe all of these services in the following pages.

Table 8.5: Evolution of the structure of care in all the sectors

	1989	1993	1997	2000	2003
CMP (5 days or +)	83	89	93	97	98
CMP (- of 5 days)	54	50	45	45	42
Day hospital	80	82	83	83	84
CATTP	41	59	69	78	84
Night hospital	63	69	61	59	55
Associative appartment	46	52	53	53	52
Accueil familial thérapeutique	32	39	44	34	35
Appartement thérapeutique	14	20	20	21	22
Atelier thérapeutique	26	19	14	14	12
Centre de post-cure	11	8	9	7	6
Centre d'accueil permanent	7	10	8	4	3
Unite d'hospitalisation à domicile	4	6	5	5	5
Centre de crise	3	6	5	4	3
Full time Hospitalization	ND	98	98	98	96

Source: Coldefy 2007[187-189] based on the activity reports of the psychiatry sectors, DREES Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques– How to read this table: in 1989, 83 % of the sectors had a CMP open during 5 days or more. In 2003, there were 817 sectors in France.

The 'full mental health services' can be classified according to the ESMS tree (the figures refer to the synthetic table):

- Hôpital Temps Plein (Complete hospitalisation): 4
- Hôpital de Nuit (Night Hospital) : 4
- Accueil Familial Thérapeutique (Therapeutic Family) : 5.2
- Centre de Postcure : 5.1
- Appartement Thérapeutique (Therapeutic Apartment) : 5.1
- Associative apartment : 5.1 (see also "residential mixed services")
- Services d'Hospitalisation à Domicile (HAD) (Home Hospitalisation) : 5.2
- Centre d'Accueil Thérapeutique à Temps Partiel (CATTP) : 7
- Hôpital de Jour (Day hospital) : 7
- Atelier Thérapeutique (Therapeutic Workplace) : 7
- Centre d'Accueil Permanent (CAP) : 3 & 8.1 & 8.2
- Centre de Crise (Crisis Centre) : 3 & 8.2
- Centre Médical Psychologique (CMP) : 8.1 & 8.2 & 9.1 & 9.2
- Psychiatrist : 9.2
- Psychologist : 9.2
- Psychoanalyst : 9.2

8.4.4.2 The 'residential mixed' services (5.1 & 5.2)

The second list is composed by residential services[qqqqq] which propose a shelter for persons who have lost the basic social references like house, job but also physical and mental health. These services are not specifically dedicated to mental patients but can also be used by persons with mental problems[202].

Many psychiatric sectors signed "Conventions", or written agreements with "mixed services" e.g. medical-social or social care providers (Coldefy 2007 p44), to enhance collaboration between different service providers. However, not much information has been found on practical consequences of these Conventions.

As indicated below, the residential mixed services all belong to the ESMS category "residential non-acute non-hospital" (the figures refer to the ESMS tree in the synthetic table):

- Lits halte santé : 5.1
- Appartements de coordination thérapeutique : 5.1
- Foyer de vie : 5.2
- Maison d'Accueil Spécialisée (MAS) (Specialized Sheltered Houses) : 5.2
- Foyer d'Accueil Médicalisé (FAM) (Medical Sheltered Housing) : 5.2
- Foyer d'hébergement pour travailleurs handicapés: 5.2
- Centre d'hébergement d'urgence et nuitées d'hôtel : 5.1
- Centre d'hébergement et de réinsertion temporaire (CHRS) : 5.1
- Maisons relais : 5.2
- Résidences accueil : 5.2
- Hébergement de stabilisation : 5.1
- Accueil familial social : 5.2
- Appartements associatifs : 5.2
- Familles gouvernantes : 5.2
- Résidences sociales : 5.1

qqqqq We find a list of residential mixed health service in a document of the 'Mission Nationale d'Appui en Santé Mentale (februari 2007) [202]

8.4.4.3 The 'Support mixed teams'

Apart from the full mental health services and the residential mixed services we find ambulatory support teams organized to help persons who have re-integration problems. Again, the mental health patients are not the only or principal target population of the "support mixed teams"; but they can use these services if they need medical-social support.

As already pointed out before, many psychiatric sectors signed "Conventions" or written agreements with "mixed services" to enhance collaboration, but not much information has been found on its practical consequences. (Coldefy 2007 p44)

The figures below refer to the ESMS tree in the synthetic table:

- Equipes psy-précarité : 9.1
- Services d'accompagnement de la vie sociale (SAVS) : 9.1
- Service d'accompagnement médico-social pour adultes handicapés (SAMSAH) : 9.1
- Groupes d'entraide mutuelle : 10

8.4.5 The 'Mental health care tree' in France

In this paragraph, more detailed information is presented on the different services listed in paragraphs 8.4.4.1, 8.4.4.2, and 8.4.4.3. A table with an overview of available services in France is presented in chapter 14.1.6.

The data in this report on "full mental health services" rely on Coldefy 2007[187-189, 192]. Unless otherwise mentioned, the included figures only deal with the "sectorized" full mental health care, and not with the "not sectorized" mental health care for which no readily available figures were found. As shown in Figure 8.4 (Chaleix 2006), the "not sectorized" mental health care represents 24% of the 56.719 full time hospitalization beds and 10% of the 17.666 partial hospitalization places in France in 2004.

To calculate services per 100.000 population, a rounded figure of 62 million inhabitants in France[rrrrr] in 2003 has been used. In 2003, there were 817 sectors in France (Coldefy 2007)

8.4.5.1 Secure services (1)

Secure services as such will not be addressed in this report, as they are out of the scope.

8.4.5.2 Residential mental health services

The 1985 reforms led to the creation of departments of psychiatry in general hospitals but most psychiatrics units remained physically separate from general hospitals[191]. In 2000, two thirds of all available beds were located in mental hospitals, one third in general hospitals (Verdoux 2007)[190].

- Generic acute
  - Hospital (2): In 2003, two thirds of the sectors are specifically involved in psychiatric hospital emergencies. The emergency intervention teams of the sectors are composed by 1.1 medical FTE, 1.3 FTE nurse and 0.9 FTE of other professionals (Coldefy, 2007, p. 41). Emergency services are growing in the inter-sector service supply, however no numbers are yet available. In France, residential hospital beds are not subdivided in "acute beds" and "non-acute beds", all beds are taken together (see further: "non-acute hospital"). In some other countries, all psychiatric beds in general hospitals are counted as "acute" beds, this is also not the case in France.

[rrrrr] http://www.insee.fr/fr/themes/tableau.asp?reg_id=0&ref_id=NATnon02151

- Non-hospital (3): in the category of "full mental health services", Centres de crise and Centres d'Accueil Permanent (CAP) were found. According to Coldefy 2007, the importance of these services is diminuishing; only 3% of the sectors provided such services in 2003 (see Table 8.5). From the category of the "residential mixed services" we can consider the "Centres d'Hébergement d'Urgence" belonging to this category; they will be dealt with in the paragraph below.

- Non-acute
  - Hospital (4)

Following the ESMS tree, we should make the difference between 'time limited' (4.1) and 'indefinite stay' (4.2) but this differentiation is not relevant for France. We discriminate "full time hospitalization" (including liaison psychiatry) and "night hospitalization".

The **full time hospitalization** in hospitals is reserved to patients who need a close watch days and nights, mostly in acute situations or for the most serious cases. As a consequence of the deinstitutionalization policy, the number of public adult psychiatric beds decreased by 49% between 1987 and 2000 (Verdoux 2007)[190]. In 2004, the total number of full-time beds amounts to 56.719 beds or 91.4/100.000 population. Of these, 43.072 beds (or 76%) belong to the sectorized psychiatry, which represents only 40% of the services (hospitals). Further, 13.647 beds (or 24%) belong to the non-sectorized psychiatry (60% of services) (see Table 8.4, Chaleix 2006). Full time hospitalization is characterized by a continuously decreasing of the length of stay since 1989 (86 days in 1989 and 41 in 2003[187-189]). This reduction is associated with the reduction of the number of beds (public "sectorized" beds: 76.000 in 1989 and 37.000 in 2003[187-189]), which was one of the goals of the sectorization. In 2003, a total of 301.925 mentally disordered persons had been hospitalized (sectorised services only), or 487/100.000 population (Coldefy 2007). When these figures are compared to the residential non-acute non-hospital full mental health services (see further), it is clear that an overwhelming part (96%) of the residential full mental health care is provided in hospitals and not in community-based services.

A special form of hospital care is the '**liaison psychiatry'**. It is a response to the occurrence of psychiatric problems in patients hospitalized for somatic reasons. In this case, specific assessment, treatment and orientation are necessary. This function is also addressed to the caregivers and to the peoples living around the patient. We find such a function in 75% of the sectors. The average liaison team is composed by 0.7 medical FTE, 1.9 FTE nurses and 0.2 FTE psychologists (Coldefy, 2007, p. 41). In 2003, these teams have realized 459.677 acts for 218.318 patients (352 patients/100.000 population) and another 72.000 liaison acts in inter-sector teams[sssss].

In **night hospitals** the patients are managed at the end of the day or of the week. The latter patients are persons living in physical autonomy in day-time but particular vulnerable when by night. The goal is thus the prevention of crises (e.g. anxiety) during the night when the patient is alone. The number of patients looked after in night hospitals has been decreasing since 1997. In 2003, 55% of the sectors used the night hospital with on average 3 places per sector[187-189]). This means about 2450 places for France, or 3.9/100.000 population.

- Non-hospital (5)

We will distinguish the residential "full mental health services" exclusively reserved for the persons with mental disorders from the "residential mixed services" where also persons with other types of social or health problems can find help.

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sssss For the other countries studied in this report, no information on availability of liaison psychiatry has been found.

Full mental health services (non-acute non-hospital)

In the category of 'full mental health services', we find three different types of accommodation taking care of a mentally disordered person in the non-hospital (sectorized) services for non acute care and for a limited time (5.1): the 'centres de post-cure ou de réadaptation' *(centre of post-cure or rehabilitation)*, the 'appartements thérapeutiques' (*therapeutic apartments)* and the 'appartements associatifs' (*Associative Apartments)*. The **'centres de post-cure ou réhabilitation'** can be installed in a hospital but have to be clearly separated from the hospitalization wards. The principal goal of these centres is the rehabilitation and reinforcement of autonomy of the patients. In 2003, a total of 1323 patients in France used this type of service (2,1/100.000 population) (Coldefy 2007 p28). The **'appartements thérapeutiques'** are located in the city to facilitate the social reintegration. Few patients are supervised by an important team of care givers. In 2003, a total of 1172 patients in France used this type of service (1.9/100.000 population) (Coldefy 2007). The patients living in **'appartements associatifs'** are considered as normal renters and the medical interventions are considered as ambulatory interventions. These apartments are fully independent of the 'referent' hospital which assures only a medical follow-up. No figures are available; but Coldefy describes a category "full time other" (indefinite time or not), including in 2003 a total 5874 patients in France (9.3/100.000 population).

We can also consider two types of services for an indefinite time (5.2), the 'accueil familial thérapeutique' *(therapeutic familial accommodation)* and the 'service d'hospitalisation à domicile' *(home hospitalisation)*. The **'accueil familial thérapeutique'** is a form of accommodation reserved to patients who can not go back to their family. They need a social and affective assistance combined with the therapeutic follow-up. In 2003, a total of 2590 patients in France used this type of service (4.1/100.000 population) (Coldefy 2007). Other patients can try to live again in a family context but may need help and assistance to rediscover the gestures of the daily life, they chose the **'service d'hospitalisation à domicile'**. Only 42 sectors were using this form of hospitalization in 2003, for 1090 patients (1.7/100.000 population) (Coldéfy, 2007, p.37[187-189].

For time-limited services and indefinite time services together, there were 19 users/100.000 population in 2003 (in sectorized psychiatric services).

Residential mixed services (non-acute non-hospital)

In the category of 'residential mixed' services, we find 6 different possibilities for a fixed period of time residence (5.1) and 9 possibilities for an indefinite stay (5.2). This paragraph is mainly based on Ponssard[202] in 2007. Only a part of the persons received in these accommodations suffers from mental health problems. No precise figures are available on the number of users suffering from a mental disorder. Entrance to most of these accommodations has to be approved by the "Commission départementale des droits et de l'autonomie des personnes handicapées".

Time-limited accommodation: the **'lits halte de soins santé'** are a recent initiative to shelter persons without any fixed residence and knowing health and social problems.[ttttt] Each institution can entail a maximum number of 30 beds for medical and paramedical cares and a therapeutic follow-up. The stay is limited to two months. This service is characterized by the obligation to sign a convention with an institution of the same geographic area having a psychiatric activity. The multidisciplinary team must be composed by minimum one physician and one nurse. The **'appartements de coordination thérapeutique'** are conceived for persons experiencing a situation of social and psychological frailty.

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ttttt Created by the law N°2005-1579, 19 décembre 2005, article 50. Decree 2006-556 of 17 mai 2006 concerning the organization conditions and the functioning of the 'lits halte soins santé' (Journal Officiel of 18 mai 2006) (http://www.localtis.fr). Also the 'Circulaire' (decree specifying how a law should be enforced) DGAS/SD.1A N° 2006/47 – 7 février 2006 (http://www.sante.gouv.fr/adm/dagpb/bo/2006/06-03/a0030038.htm)

The personnel have to offer the medical and psycho-social coordination. They are attached to an hospital or a CMP.[uuuuu] In the same category of accommodations, we find also the **'centres d'hébergement d'urgence'** (CHU) and the **'nuitées d'hôtels'**. The two services concern individuals without any place to live. They may stay in these places from one night until several months. For persons experiencing major difficulties (economic, familial, residential, social insertion and health), the State authorises also public and private establishments called **'centres d'hébergement et de reinsertion sociale'** (CHRS). Following the same philosophy of autonomy and social re-integration of the individuals, the State creates in 1994 the **'résidences sociales'**.[vvvvv] They offer one of two beds instead of a dormitory as in the CHU. When al the presented accommodations are not adequate, the '**hébergement de stabilisation**' can be considered as a complementary residence for a short period of time.

Besides, the residential mixed services organised for a limited period, we find services offering the same services for a longer or unlimited period. We present briefly the 9 types of this kind of accommodation. The **'foyers de vie ou foyers occupationnels'** shelter individuals who are unable to work. Nevertheless, they are able to participate to leisure activities.[wwwww] The persons accepted in **'maisons d'accueil spécialisées'** (MAS) are not able to assure their activities of daily living. They need a regular medical supervision but receive also other services. The patients of the **'foyers d'accueil médicalisés' (FAM)** are very deeply handicapped and need constant care and medical supervision. In 2001, more than 55 % of the residents of MAS and FAM suffered of intellectual and mental problems (Vanovermeir 2004, p.185 and 226[203]. The Psychiatric and Mental health Plan 2005 – 2008 (Plan Psychiatrie et Santé Mentale – **PSM**)[204] plans to create 7 500 new places in MAS and FAM during the period 2005 – 2008. We find also the '**foyers d'hébergement pour travailleurs handicapés**' which are reserved for adults exercising an activity during the day[xxxxx]. These accommodations do not offer medical care but only a social support and medical acts are performed by independent physicians. The '**maisons relais**', is an experimental accommodation sheltering people who cannot find housing for social, psychological or psychiatric reasons. They are organized as a cluster of 10 to 25 apartments with a collective room. The residents can receive medico-psychological and social support assured by the host. The '**résidences accueil**'[yyyyy] is also an experimental type of accommodation based on the same principles as the 'maisons relais' but specifically developed to shelter people who have psychological problems linked with chronic mental pathology.[zzzzz] The responsible of this accommodation has to contract a convention with a team of the psychiatric sector. For persons who have no more capacity to stay alone at home, there exists the system a familial social sheltering (**accueil familial social**).[aaaaaa] The host receives remuneration from the State. The '**appartements associatifs**' are reserved to autonomous persons. These accommodations are managed by an association which receives the warranty of the communes. The PMS plans[204] to create 500 new 'appartements associatifs' during the period 2005 – 2008. Persons who cannot live alone can be sheltered by a '**famille gouvernante**' if their situation does not require a hospitalization. This concept was developed by the UDAF (Union départementale des associations familiales) of the Marne. This is a specific category of apartments associatifs with the intervention of a 'gouvernante' living in the same building as the residents[204]. The gouvernante provides support to the persons for the acts of the daily live and is responsible for cooking, hygiene, medication, medical and administrative formalities etc. He/she is in charge of 5 or 6 persons living in two apartments.

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uuuuu Decree N°2002-1227, 2002 3td October. Circulaire DGS/DGAS/DSS/2002/551, 2002 30th October

vvvvv Decree N°94.1128, 94.1129 and 94.1130 – 1994 23th December and Circulaire 2006 4th july – Direction générale de l'urbanisme, de l'habitat et de la construction et direction générale de l'action sociale

wwwww Code de l'action sociale et des familles L312-1, L344-5, R344-29 et suivants, D344-35 et suivants (http://vosdroits.service-public.fr/particuliers/F2005.xhtml?p=1)

xxxxx Code de l'action sociale et des familles L344-5 (http://vosdroits.service-public.fr)

yyyyy Although this type of accommodation belongs to the « full mental health services », it is mentioned here because it is financed by the regional departments and not by the social security.

zzzzz Note d'information DGAS/PIA/PHAN N° 2006-523 – 16 novembre 2006 (http://www.sante.gouv.fr/adm/dagpb/bo/2007/07-01/a0010053.htm)

aaaaaa Note d'information DGAS/2C/2005/283 – 15 juin 2005 (http://www.famidac.fr/article259.html)

Table 8.6: Evolution of the number of MAS and places

Years	Number of MAS	Number of places	Evolution (%)
1998 (*)	297	11 775	
2001 (**)	360	14 500	23,1%
2005 (***)	415	16 703	15,2%

Sources: (*)http://archives.handicap.gouv.fr,(**) Vanovermeir 2004, p. 173[203], (***)Burckbuchler 2004[205]

Table 8.7: Evolution of the number of FAM and places

Years	Number of FAM	Number of places	Evolution (%)
1998 (*)	191	6 235	
2001 (**)	278	9 200	47,6%
2005 (***)	347	10 309	12,1%

Sources: (*)http://archives.handicap.gouv.fr,(**) Vanovermeir 2004, p.207[203], (***)[205]

8.4.5.3 Day and structured activity

Information on non-sectorized "full mental health services" was only found for "day hospitals". No information on other than "full mental health services" was found; however, 20% of the psychiatric sectors have an agreement ("Convention") with a local service for employment, professional education, or social re-integration (Coldefy 2007 p44)[187-189].

- Acute (6) No specific and accurate information was found on this point.
- Non-acute (7)

The number of users of this type of services doubled between 1989 and 2003 (Coldefy 2007, p30). The structure of the ESMS tree makes the difference between 'High' and 'Low' intensity. This distinction corresponds to the two types of non-acute day mental services: on the one hand, the *day hospital* and on the other hand, the 'atelier thérapeutique' (*therapeutic workplace)* and the *Centre d'Accueil Thérapeutique à Temps Partiel (CATTP)*. Despite a formal principle distinction, the experts consider that the distinction on the field is not always so clear because the CATTP is a very flexible organization[187-189]. The evolution of the number of CATTP and day hospitals characterizes the development of structures closer to the patient's living place because 62% of the day hospital places and 88 % of the CATTP are situated outside the 'attached institution' in 2003[187-189].

- o High intensity (7.1)

In the **day hospital**, the patients receive polyvalent and intensive care during all or a part of the day and during one or more days of the week. Individualized therapeutic protocols are revised periodically to avoid the 'chronicization' of the patient. The goal is the re-integration of the patient into the society. Sectorized day hospitals[187-189] accounted for 46.883 patients in 2003, or 75,6/100.000 population/year. Non-sectorized part-time hospitalization accounts for 10% of all part-time hospitalization places (Chaleix 2006). Given the fact that night hospitalization is not common (see above), it can be estimated that another 8,4 patients/100.000 population/year use non-sectorized day hospitalization; so that day hospitals (sectorized and non-sectorized) were used by 84 patients/100.000 population/year.

- o Low intensity (7.2)

The activities in a **'centre d'accueil thérapeutique à temps partiel'** (CATTP) are less intensive. The goals of the interventions consist in maintaining or promoting the patient's autonomy by support and group therapy. The CATTP is the normal follow-up for patients coming from day hospital because the interventions are more oriented to the social reintegration of the patients. Since 1995, the CATTP is the more used part time intervention system with 68.837 patients (sectorized psychiatry only) or 111/100.000 population[187-189] in 2003.

The principal goal of the **'atelier thérapeutique'** is the professional and social rehabilitation using artistic, traditional and sports activities to develop the relational capacities of the patients. In 2003, this service was used by 4882 patients (7.9/100.000 population, sectorized psychiatry only)[187-189].

Other, less well defined services exist, in 2003 they served 14.897 patients (24/100.000 population)

8.4.5.4 Out-patient and community mental health services

This paragraph contains information on "full mental health services": *Centres médico-psychologiques or CMP, Centres d'Accueil Permanents or CAP, and Centres de crise.* (CAP and crisis centres can also provide residential care, see "residential generic acute non-hospital" services). *'Equipes psy-précarité'* can also considered to be full mental health services. For the "full mental health services", no information on non-sectorized ambulatory services was found; ambulatory services by private psychiatrists or psychologists are mentioned briefly.

"Mixed" support teams that serve persons with all types of disabilities (not only mental disorders) are also discussed, they belong to the category "continuing care, mobile": *'service d'accompagnement à la vie sociale'* (SAVH), and *'service d'accompagnement medico-social pour adultes handicapés'* (SAMSAH).

Although hospitalization remains a very common practice in France, the ambulatory mental health care services become more and more important in mental health care. Between 1989 and 2003, the number of consultations in the CMP has doubled. According to Coldefy et al[187-189], outpatient psychiatric care comprised 86% of all psychiatric care in 2003, as compared to 79% in 1989.

- Emergency care (8)
  - Mobile (8.1)

A few CMP provide mobile services in Centres d'Accueil Permanents (in non-residential form). Emergency outreaching is not common practice in France (as underlined in personal communications with French experts).

  - Non-mobile (8.2)

In this category, we find the CMP (**Centres medico-psychologiques**) who can take care in case of emergency; 83% of the sectors provide emergency CMP care (Coldefy 2007 p39). CMP can also rely on emergency care centres (in this case, we speak about CAP or **Centres d'Accueil Permanents**). They organise emergency measures and, if necessary, the first needed care. The crisis centres (**Centres de crise**) can also intervene in case of emergency situations and acute distress. According to Coldefy 2007, the importance of CAP and crisis centres is diminuishing; only 3% of the sectors provided such services in 2003 (see Table 8.5). CAP and crisis centres can also provide residential care (see "residential generic acute non-hospital" services).

- Continuing care (9)
  - Mobile (9.1)

The **CMP,** the cornerstone of the psychiatric sector, can offer ambulatory care at the living place of the patients. In 2003, 184.520 patients used this type of service, or 297patients/100.000 population /year. This is about 19% of all patients served by the CMP in 2003.

The '**équipes psy-précarité**' are mobile teams planned by the Psychiatric and Mental health plan[197]. They are specialized in psychiatric care and are composed by physicians, nurses and psychologists.[bbbbbb] These teams follow people experiencing major difficulties in access to mental health care, and try to motivate the patients to participate in regular care. They have also to promote the interface between the psychiatric sectors and the socials teams.

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bbbbbb Circulaire DHOS/02/DGS/6C/DGAS/1A/1B/521 du 23 novembre 2005 (cited in [202])

In the group of the "mixed support teams", two types of mobile teams offer social and medico-social support[cccccc] to persons with different types of disabilities, but their role for persons with a mental disorder has been emphasized in the Mental Health Plan 2005-2008 (Ponssard 2007)[202]. The first one, the '**service d'accompagnement à la vie sociale**' (SAVH), gives a support to patients to restore familial, social, professional, scholar or academic relations. These teams are composed of social assistants, psychologists, advisers in social and familial economy, educators. The second one, '**the service d'accompagnement medico-social pour adultes handicapés**' (SAMSAH), is charged of a complementary mission. Indeed, it has been clearly underlined by several reports, especially MP Alain Milon's report in April 2009, that these teams play a major role in the quality of long-term observance of medication. The team includes always a physician and has to offer a medical and paramedical support. All the interventions of these two teams are implemented at home of the patient or on every place where he/she exercises his/her activities.

- Non-mobile (9.2)

The **CMP or Centres medico-psychologiques** are the cornerstone of the psychiatric sector. As already mentioned (see 8.4.2.1), there were 2070 CMPs in 2003 in the 817 sectors.

In 2003, 804.909 patients were seen in consultation at the CMP, or 1298 patients/100.000 population/year. This is about 81% of all patients served by the CMP in 2003; the rest (19%) of the consultations take place at the living place of the patient (see above) (Coldefy 2007).

Psychiatrists, psycho-analists and psychologists also provide ambulatory continuing, non-mobile care, that can be reimbursed or non reimbursed. The consultations of psychiatrists are covered in the general scheme. The majority of the contacts between the psychiatrist and his patient are consultations at the psychiatrist practice[dddddd]. We find also out-patient consultations in the hospital and, more rarely, in private clinics[186, 206]. We find three types of psychiatrists in function of the applied price system.

- The psychiatrists of the sector 1 (6 psychiatrists on 10): apply fixed tariffs. The compulsory health insurance reimburses 70 % of the price and the patient has to pay the co-payment. This co-payment can be covered by the complementary insurance of the patient. The price of the consultation if fully reimbursed for patients beneficiaries of the ALD (affection of long duration) system.
- The psychiatrists of the sector 2: determine freely their tariffs with 'tact and moderation'. The reimbursement (70 %) is based on the tariff of sector 1. Complementary insurances can cover completely or partially the charge exceeding the statutory fee for a fixed number of all the consultations.
- The psychiatrists working out of the convention. They are fully free to fix their tariffs and the compulsory health care insurance reimbursed only a lump sum of 1,46 €.

The optimal reimbursement of the health care system is only applied when the patients respect the coordinated and individualized care path 'parcours de soins coordonné et individualisé'. Following this system, each patient older than 16 years has to choose a 'reference physician' (médecin traitant) who play the role of a gate-keeper. Only the patients younger than 26 years are free to consult a psychiatrist outside the care path.

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cccccc Loi 2002-2 du 02 janvier 2002 et décret N° 2005-223 du 11 mars 2005 (Cited by Ponssard 2006)

dddddd 80 % following an inquiry of INSEE realized between October 2002 and September 2003. Almost 1 200 000 persons have declared a contact with a psychiatrist, a psychologist or a psychoanalyst during this inquiry, this represents 2 % of the population (see Chapireau 2006[206])

On the other hand, the consultations of psychoanalysts[eeeeee] and psychologists[ffffff] in the ambulant sector (at the practitioner's office) are not reimbursed and are fully charged to the patients. Some complementary insurances cover partially a certain number of sessions.

8.4.5.5 Self-help and non-professional mental health services

So far *care* by volunteers or family has never been acknowledged, neither legally nor financially. Family support however plays an important role, especially in a context of non institutionalized patient management and increased home care. As to self-help, the Plan Santé Mentale 2005-2008 (PSM)[197] provides subsidies to support the creation of '**groupes d'entraide mutuelle**' (GEM)[gggggg] to fight against isolation and to support persons suffering of psychic problems[hhhhhh].

In the organization of health care in general, *users and family associations* have gained over the last decade a growing position (Verdoux, 2007)[190]. Their role has been specified in the recent laws, and members of patients' associations are now part of hospital management boards, national consensus conferences etc. Nevertheless, the mental health care users associations are represented in only 16% of the sectors (2003). The representation of their families is hardly higher with 23 % of the sectors. This situation could change because the Mental Health Plan 2005-2008 considers the intervention of the care user and his family as a priority for the future.

Key points

- **Desinstitutionalization has been the main trend of the French policy for the last decades.**
- **Sectorization is the key organizational principle of mental health care supply. However it did not lead to massive closure of psychiatric hospitals (like in some other western countries)**
- **Hospital beds decreased significantly, day care doubled in 15 years and outpatient care grew constantly.**
- **However, for patients in need of residential care, there are very few options outside the traditional hospitalization.**
- **Mapping of the territory and distribution of health care supply remains uneven across regions. Actual access to the whole range of services is problematic in some geographical areas.**

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eeeeee Psychoanalysis : « Method of clinical psychology, investigation of the deep psychical process ; therapeutic method coming from this investigation, these methods were elaborated by Sigmund Freud and its disciples (definition of Alain Rey cited by Chapireau[206])

ffffff Psychologist : the required qualifications to act as psychologist are fixed by the Law 85-772 of 27 July 1985 [206].

gggggg Loi N°2005-102 du 11 février 2005. Circulaire DGAS/PHAN/3B/2005/418 du 29 août 2005 (cited in Ponssard[202])

hhhhhh We find an appraisal of the organization and the financing of these GEM in the circulaire N°DGAS/3B/2007 du 30 mars 2007. In 2006, the State has delegated 18 M€ to the DRASS (Directions Régionales des Affaires Sanitaires et Sociales) to finance 259 GEM among which 142 ware created in 2006. 20 M€ were planned for 2007. 14 department on 100 have not created GEM in 2006 and 17 departments had only one GEM.

8.5 FINANCING OF THE MENTAL HEALTH CARE SECTOR

8.5.1 Global data

The total French health expenditure was 10.5% of GDP in 2003 (Verdoux 2007)[190]. According to Verdoux (2007), the mental health budget represented 9.4% of the general health budget in 1998. According to Coldefy (2007)[187-189], the mental health budget (not including prevention) represented 10.6% of the general health budget in 2005. The WHO Mental health atlas 2005[iiiii] mentions that 8% of the total health budget is spent on mental health. The cost of full time psychiatric hospitalizations represents 80% of mental health expenditure (Verdoux 2007).

In France, as in many other countries, the whole range of care provided to persons with mental disorders are matters for two different budgets, both from a legal and financial point of view, and the rationale behind is the following:

- **Clinical care, strictly speaking,** that is provided by health professionals only (GPs, Psychiatrists, Nurses) are matters for "Health Care" and thus funded by the Social Security system.
- **Social and psycho-social care** (self-support, activities of daily living,...) that are provided by other professionals are funded by the local branches of national public institutions and/or by local public authorities, but that are not a matter for Health Care as such.
- **Combined funding** can be implemented on very specific subjects.

8.5.2 Data per sector of activities

In the table below, financing is described following the ESMS tree if the data are available. Main references are Coldefy 2007[187-189] and Ponssard 2007[202].

Table 8.8: Description of the financing of the different mental health (pure and mixed) institutions and teams

Services or institutions	Financing
Full Mental Health Services	
Complete hospitalisation	Social security - ONDAM
Night Hospital	Social security - ONDAM
Accueil familial thérapeutique	Social security - ONDAM
Centre de postcure	Social security - ONDAM
Appartement thérapeutique	Social security - ONDAM
Centre d'Accueil Thérapeutique à Temps Partiel (CATTP)	Social security - ONDAM
Service d'hospitalisation à Domicile (HAD)	Social security - ONDAM
Day Hospital	Social security - ONDAM
Atelier thérapeutique	Social security - ONDAM
Centre d'Accueil Permanent (CAP)	Social security - ONDAM
Centre de crise	Social security - ONDAM
Centre Médical Psychologique (CMP)	Social security - ONDAM
Unité d'hospitalisation somatique	Social security - ONDAM
Institution substitutive au domicile	Social security - ONDAM
Apartement associatif	Social security - ONDAM
Psychiatrist	Social security - ONDAM
Psychologist	Social security - ONDAM
Psychoanalyst	Social security - ONDAM
Residential Mixed Services	
Lits haltes soins santé (LHSS)	ONDAM medical-social. Global budget based on a lump sum per day and per bed. 90 euros for 2006 and revised each year.
Appartements de coordination thérapeutique	ONDAM medical-social. The food costs are on

[iiiii] http://www.who.int/mental_health/evidence/atlas/profiles_countries_e_i.pdf

(ACT)	charge of the residents. Financial interventions of the collectivities and co-payment of the residents are deducted of the global budget
Centres d'hébergement d'urgence (CHU) et nuitées d'hôtel	Ministère de l'emploi, de la cohésion sociale et du logement (Direction générale de l'Activité Sociale – DGAS)
Nuitées d'hôtel	Direction Départementale des Affaires sanitaires et Sociales (DDASS)
Centres d'hébergement et de réinsertion sociale (CHRS)	Ministère de l'emploi, de la cohésion sociale et du logement - Direction Départementale des Affaires sanitaires et Sociales (DDASS) – financial participation of the residents in function of their revenues (between 9 and 40 % depending of the familial situation)[iiiiij]
Résidences sociales	Several financing : aide à la gestion locative, « Département » - (General Council), fond de solidarité pour le logement
Hébergement de stabilisation	Direction Départementale des Affaires sanitaires et Sociales (DDASS)
Foyer de vie ou foyer occupationnel	« Département » - (General Council) and personal intervention of the resident. This financial intervention is based on the revenue of the resident.
Maison d'Accueil Spécialisée (MAS)	Fully financed by the social security by means of a daily lump sum. After a period of 45 days, the patient has to pay a per diem intervention
Foyer d'Accueil Spécialisé (FAS)	Residence financed by the departmental social aid / aide sociale départementale (General Council). Cares are financed by social security – ONDAM.
Foyer d'hébergement pour travailleurs handicapés	The financial charge for the resident is calculated on basis of their resources giving an upper limit to leave him a minimum financial autonomy. The department can cover a part of the costs. Medical costs are covered by the social security and paid by a fee for service.
Résidences accueil	DRASS (Direction Régionale des Affaires Sanitaires et Sociales) and Direction de l'équipement. The host receives a lump sum per place and per day from the State.
Maisons – relais	Functioning financed by the State. Resident pays a monthly sum equal to 15 % of their resources.
Accueil familial social	« Département » (General Council)
Appartements associatifs	The patient (resident) pays a rent and can receive a financial help in function of their resources.
Familles gouvernantes	The 'gouvernante' is paid by the residents who can receive a special allocation from the department (allocation compensatrice pour tierce personne)
Support Mixed Teams	
Equipes psy-précarité	Reimbursement of the medical acts – social security
Service d'accompagnement à la vie sociale (SAVS)	« Département » (General Council)
Service d'accompagnement médico-social pour adultes handicapés (SAMSAH)	Social security and « Département » (General Council)
Groupes d'entraide mutuelle (GEM)	Subsidization from the State (average amount per GEM: 75 000 euros

iiiiij See http://www.adai13.asso.fr/fiches/log/log_chrs.htm

8.5.3 Key issues on financing of psychiatric care

The general principle that divides funding between mental health or clinical care, and (psycho-) social care or welfare, has several draw-backs.

8.5.3.1 Lack of funding continuity between clinical and psycho-social care

One of the weaknesses of the separation of health and social care budgets is that it does not guarantee funding continuity between purely clinical care, psycho-social care, and social support, as these different types of care are matters for different budgets and are within the remit of different institutions. This problem was clearly identified by the Clery-Melin Report in 2003 (Authors: Dr Clery-Melin, Pr Kovess, and Dr Pascal; see paragraph 8.4.3.1). The Mental Health Plan 2005-2008 augmented the budget for psycho-social care supply (see paragraph 8.4.3.2). However, the current situation is still far from being satisfactory.

8.5.3.2 Local authorities responsible for funding of psycho-social care

As underlined by the Milon report and also by the Haute Autorité de Santé, social and psycho-social care is largely funded by local public authorities, especially the "Département" (French equivalent of the Belgian "Province") whose governing body is the "Conseil Général / General Council". However, this can be hampered by the following factors:

- Local authorities in France are entrusted with administrative or day-to-day budget management but they have **no regulatory power**. Therefore, today's institutional framework does not leave them much room for manoeuvre.
- The financial support they can bring basically depends on the own **financial capacity of each "Département",** and its wealth. This takes us back to the notion of unequal access to health care in the different French "Departement".
- In today's legal framework, the latter **are not under a legal obligation to guarantee a specific level of funding** (amount of money, number of beds, level of workforce, etc…) to mental health care.
- This puts things back in the wider context of local political arbitration, as actual funding and funding largely depend on a **political commitment**. Therefore, there is no guarantee that the patients' needs can actually be met.

8.5.3.3 Transparency problems

Important problems remain unsolved in the field of psychiatric care, which has an impact on the optimal use of health care funds. One of them is the **lack of transparency** of psychiatric departments: the main hindering factor for an effective use of healthcare funding is the lack of data and detailed information concerning the psychiatrists' activity in public hospitals. This problem takes us back to a problem of transparency culture, as underlined in personal contacts with French experts.

Key points

- **Continuity of funding between purely clinical care and psycho-social care is not guaranteed.**
- **Funding of psycho-social care largely depends on the financial capacity of local authorities, and is very uneven across regions.**
- **Financial issues are difficult to address, because of a lack of transparency of psychiatric departments.**

8.6 THE FRENCH MENTAL HEALTH CARE ORGANIZATION: DISCUSSION

During the last decades, the cornerstones of the reforms of the French mental health care system were "de-institutionalization" and "sectorization".

Since then, the "de-institutionalization" led to a marked decrease in hospital beds: between 1987 and 2000, the number of public adult psychiatric beds decreased by 49% (Verdoux 2007)[190]. Nevertheless, hospital-based care has still an overwhelming importance, and is associated with a marked underdevelopment of residential community services and lack of adapted housing for the most disabled patients (Verdoux H 2007)[190] (Coldefy, 2007, p. 36)[187-189].

The goals of the "sectorization" policy were to promote the development of community care, to assure the access to mental health care for every-one[190] and to make psychiatry evolve outside the hospital[191]. At the centre of the sector, the multidisciplinary teams of the CMPs (Centre medico-psychologique) should provide patient care, continuity of care, and coordination of medical care and psycho-social support. The last decades, outpatient ambulatory services by the CMP grew constantly and day care doubled in 15 years (Coldefy 2007).

However, several recent reports emphasize that many of the initial goals have not been reached so far: the Cléry-Melin report (2003), the assessment of the Mental Health Plan 2005-2008 by the Department of Health in 2006, the publication by Coldefy (2007 and 2009), the Rapport Couty (2009), the Rapport Milon (2009), the IRDES report (2009) (see paragraph 8.4.3). They all mention the same fundamental problems of domination of hospital care, uneven distribution of service supply, long waiting lists and lack of coordination and continuity of care.

9 THE NETHERLANDS

9.1 LITERATURE SEARCH: METHODOLOGY

See general methodology. No information (references, data…) has been included after August 31, 2009.

9.2 GENERAL HEALTH CARE ORGANISATION

9.2.1 History

In the 1970's centralized government coordination and planning was the leading principle and model in Dutch health care. The government had ultimate control over the planning of care facilities, the pricing of provisions, and the macroeconomics of health care expenditures. Since the late 1980's several policy reformations took place[kkkkkk], whereby the central government (the Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport, VWS)) decentralized certain competencies to provincial and local governments. Since then, the regional government had the responsibility to develop a planning for care facilities based on an analysis of local needs and availability of services. Draft proposals were then submitted to the health minister for approval, after receiving advice from the Hospital Provision Board.

The Dutch health insurance model separated three health insurance compartments.

1. The first, national compartment covered the exceptional medical expenses associated with long-term care or high-cost treatment, where the expense is such that it cannot be borne by individuals or adequately covered by private insurance. This compartment of care was covered under the Exceptional Medical Expenses Act (AWBZ).
2. The second compartment covered regular, necessary medical care under the Sickness Fund Act (ZFW). Included were the sickness fund insurance (compulsory for those under a certain income) and the private health insurers (mostly voluntary).
3. The third compartment covered the voluntary supplementary forms of care regarded as being less necessary. The costs are covered by private medical insurance. Supplementary insurance can be taken out to cover the costs of these kinds of care, which are not included in the first or second compartment (e.g. dental insurance and extensions of the insurance package to cover specific items, such as glasses or a higher standard of hospital accommodation).

9.2.2 Recent changes

9.2.2.1 Health insurance act (ZVW)

Since a few years, important new changes have been introduced, under the credo "Less government, more market". The implementation of the Health Insurance Act (Zorgverzekeringswet (ZVW); January 1, 2006) is the first step in a reform process that is planned to last to at least 2012[llllll]. The new legislation led to the abolishment of previous health insurance laws (Sickness Fund Act (ZFW), Hospital Planning Law etc). The Health Insurance Act makes health coverage by a private health insurer statutory for everybody. Insurers are at the same time responsible for "buying" health care from health care providers; they must provide a standard benefits package (included e.g. general practitioners, drugs) and can't deny access to citizens, but they are free to offer additional services or different packages for different prices. Since insurers can "buy" services from different care providers, they can negotiate on prices and competition among the care providers is introduced. Also, because citizens can choose freely their insurer, there are incentives for the insurers to provide best quality at the best price.

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kkkkkk http://www.euro.who.int/Document/E84949.pdf
llllll http://www.hpm.org

To prevent "cream skimming", there is a complementary system at the national level that compensates insurers for the risk of insuring certain categories of patients, e.g. patients with chronic illnesses. To make it possible for insurers and care providers to compare prices for services provided mainly in hospitals and by the mental health care services (GGZ, Geestelijke Gezondheidszorg), the DBC system (introduced[mmmmmm] in 2005) is used (see further).

9.2.2.2 Exceptional Medical Expenses Act (AWBZ)

Whereas the new system that was started in 2006 applies to the previous "secondary" and "third" insurance compartment, all citizens remain covered by the national, statutory "first" compartment, the Exceptional Medical Expenses Act (AWBZ) scheme for a wide range of chronic care services such as home care and care in nursing homes. However, the AWBZ recently went through several changes as well.

Since 2003, care reimbursed by the AWBZ typically is not allowed based on a type of institution or care service, but on "Functional indications". There exist 5 main Function indication domains: nursing, treatment, accommodation, personal care (help with ADL i.e. activities of daily living), guidance (help to organize life, provision of daytime activities). The decision whether someone is allowed reimbursement for services in one or more of these AWBZ domains, belongs to the competency of a national, independent agency (CIZ, Centraal Indicatieorgaan Zorg). If someone has an indication for a certain domain, he can choose which type of service within this domain is most apt to his personal situation or which service he prefers. There is a small out-of-pocket contribution for the service users. A second reformation, effective from 1st Jan 2009, abolished the uniform AWBZ reimbursement for long-term intramural care, and adapted it to the intensity of care (zorgzwaarte[nnnnnn]): reimbursement is higher for persons in need of more intensive care.

The third and probably the most important change, is the decision to downsize the AWBZ. It was felt that the services belonging to its responsibility had become too broad: originally only long-term intramural care was subsidized, but due to the gradual reconversion from intramural to extramural care, other types of care became reimbursed as well, such as home nursing etc. It was decided to return to the original AWBZ indications: insurance for exceptional medical expenses associated with long-term care or high-cost treatment, where the expense is such that it cannot be borne by individuals or adequately covered by private insurance. Services not in line with this mission would be positioned under the ZVW (Zorgverzekeringswet, Health Insurance Act 2006), or under the WMO (Wet Maatschappelijke ondersteuning, Social support Act, 2007).

9.2.2.3 Social support Act (WMO)

The WMO[oooooo] or "Wet Maatschappelijke ondersteuning", effective as from 2007, puts an end to various rules and regulations for handicapped people and the elderly. It encompasses the Services for the Disabled Act, the Social Welfare Act and, as already mentioned, parts of the Exceptional Medical Expenses Act (AWBZ). The WMO makes the municipalities responsible for setting up social support and welfare, such as support to run the household, help with mobility e.g. wheel chairs or an elevator at home, support to carers and volunteers, psychosocial support e.g. to homeless people etc. It was felt that the municipalities are more in the position to estimate the needs of citizens in these domains than the national Government, and that coordination between the welfare services under their responsibility would be easier. Also, it would be easier to control the budgets since fixed budgets would be distributed among the municipalities, which would be responsible for dividing it according to the urgency of the different local needs.

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mmmmmm http://www.minvws.nl/dossiers/dbc/
nnnnnn http://www.minvws.nl/dossiers/zorgzwaartebekostiging/
oooooo http://www.minvws.nl/en/

9.3 GENERAL FINANCING OF HEALTH CARE

In the Netherlands, the total 2004 health expenditure amounted to 9.2% of the GDP[pppppp]. In 2005 public sources financed 65.7% of the total health expenditure. In 2006 this proportion had risen to around 78%[qqqqqq].

The Dutch statutory health insurance system (ZVW, 2006) is financed by a mixture of income-related contributions and premiums paid by the insured. Contributions are collected centrally and distributed among insurers based on a risk-adjusted capitation formula. Additionally, as already explained, each individual has to purchase his own insurance by paying a contribution (premium) to an insurer of his choice. In 2006 the average annual premium was €1050. The government pays for the premiums of children up to the age of 18.

In February 2005, a DRG-like case-mix system based on 'diagnosis treatment combinations' (DBCs) was introduced for the registration and reimbursement of hospital and medical specialist care as well as mental health care[rrrrrr]. The main objectives of the introduction of the DBC system were to increase transparency of hospital and specialist care, to realise the transformation from a supply-led to a demand-led system, increase efficiency and facilitate regulated competition between health care providers.

DBCs are defined as the whole set of activities (diagnostic and therapeutic interventions) of the hospital and medical specialists from start till discharge. Episodes of care are identified, and in the DBC case-mix system the type of care (regular, emergency & chronic), the diagnosis (ICD 10 coding) and the treatment (outpatient or residential; nature of treatment) have to be identified.

In the DBC case-mix system, a distinction is made between DBCs with fixed prices (list A) and with negotiable prices (list B). For DBCs on list A, fixed tariffs exist that hospitals have to charge to health insurers and patients. These tariffs apply to all hospitals and include two separate components: a reimbursement of hospital costs and an honorarium for medical specialists. The level of production of a hospital is negotiated based on these DBC's with insurers. If the expenses of the hospital exceed the allowable costs, the loss is for account of the hospital. Prices of list B DBCs result from negotiations between hospitals and health insurers. Only elective DBCs have been selected for list B. Health insurers may employ different DBC prices for different hospitals. Likewise, hospitals may negotiate different prices for the same DBC with different health insurers.

The initially developed DBC system appears to be too complex (more than 30 000 DBCs etc.). For this reason, mid 2009 the DOT system has been introduced, currently only for registration, and as from 2011 on also for cost declaration. The DOT system ("DBC's Op weg naar Transparantie", DBCs on their way to Transparency) uses the ICD-10 classification and contains about 3000 "product classes". The introduction of the DBC-based financing of the hospitals is also complex, and it has been decided that[ssssss] for the year 2009, DBCs of list B can maximally account for 34% of the full hospital cost.

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pppppp WHO 2008

qqqqqq http://www.commonwealthfund.org/usr_doc/LSE_Country_Profiles.pdf?section=4061

rrrrrr Cost assessment and price setting of inpatient care in the Netherlands. The DBC case-mix system J. B. Oostenbrink & F. F. H. Rutten Health Care Manage Sci (2006) 9: 287–294

ssssss http://www.minvws.nl/dossiers/dbc/voor-medewerkers-in-de-zorg/dbcs-in-ziekenhuizen/

9.4 MENTAL HEALTH CARE ORGANISATION

9.4.1 History

Mental health care in the Netherlands has been through major reforms in the second half of last century[ttttt].

Since the early '1980s reformations led to the introduction of alternatives for residential psychiatric treatment and care. The creation of "Regional centres for ambulatory mental health care (RIAGG)" was intended to foresee in easily accessible ambulatory treatment. In the same period the "Regional institutions for sheltered living, regionale instellingen beschermd wonen, RIBW) were created for people that needed supervision, but could live outside the hospital infrastructure. Psychiatric care was taken out of the insurance package covered by the Sickness fund act (ZVW) and fully placed under the Exceptional medical expenses act (AWBZ), to facilitate the substitution of intramural care by extramural care such as RIAGG and RIBW.

In the next reformation wave that started at the beginning of the 1990's, collaborative practice between mental health care organisations was heavily promoted; even the merging of several mental health care institutions was stimulated. Each region should provide all types of care services, in an integrated way, to make sure that continuity of care could be guaranteed (continuity of care or "ketenzorg"). The regions succeeded in their mission ("regionalisering"): by 2005, forty large *integrated mental health care facilities* were responsible for most of the Dutch mental health cure and care supply; and the whole country had no more than 3 general psychiatric hospitals left (see Figure 9.1). This will be further dealt with below.

9.4.2 Specific programmes: care programs and care circuits

During the same period, the development of *Mental health Care programs*[uuuuuu] was stimulated as well; these programs should be as much as possible based on solid scientific evidence. A (mental health) care program[vvvvv] is a meaningful set of cure and care activities for a certain target group, e.g. depressions in the elderly. Diagnosis, different treatment options, support, and after-care all belong to the same care program. For each individual patient, a care plan can be constructed within the framework of the care program. Basic care programs are provided by the Trimbos Institute (see further) and exist for e.g. depression, eating disorders, anxiety disorders, double diagnoses, and also for severe and persistent psychiatric problems. Most (but not all) of these Basic care programs are organized around a specific diagnostic category. The Trimbos Institute estimated in 2007 that 60% of the mental health care services used care programs, and that 850 (regional) care programs were used for 40 different target groups. In a next step, these 850 care programs will be evaluated on their content and quality.

Gradually a consensus grew that is most practical to distinguish 8 general "mental health *Care circuits*": children and adolescents, adults, elderly persons, forensic psychiatry, addiction care, long-term care and accommodation, primary mental health care and mental health prevention.

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ttttt http://www.minvws.nl/kamerstukken/cz/2008/aanbieding-van-de-trendrapportage-ggz-2008.asp

uuuuuu http://www.trimbos.nl/publicaties/2007/06/zorgprogrammering-in-de-ggz-zet-door--de-stand-van-zaken-in-2006

vvvvv Programma's in de GGZ, Handreiking voor zorgprogrammering. Verburg, Hv; Rest, Ev; Trimbos institute 2005.

9.4.3 Most recent changes

At the beginning of the new century, criticisms on the care organization grew, mainly because mental health care services were integrated with other mental health care services but not with other cure and care service provisions ("verkokering"). This led to an isolated position of mental health cure and care, and also of its patients; and it also gave the large care providers (too) much influence and the patients too little freedom of choice. Moreover, it was felt that the treatment of mental disorders belongs to the field of medical care and the ZVW, and it was stressed that this type of care often does not correspond to the field of AWBZ.

The most recent policy reforms in the Dutch mental health care system date from 2006, and take as a starting point that mental health care should be part of a network of other (health) care and welfare facilities. This network should not be limited to mental health care services, but should be as much as possible implemented in the general care provision for other service users, e.g. other persons in need of medical care, congenitally handicapped persons, the elderly, etc. Based on this vision it was decided to

- transfer the "medical" component of mental health care from AWBZ to ZVW (health care sector);
- transfer the "public" component of mental health care from AWBZ to WMO (social care and welfare);
- transfer the financing of forensic psychiatry from AWBZ to the Department of justice (see further).

An important additional change compared to previous policy periods is the introduction of a *national* provision of curative ambulatory mental health care (given the introduction of private health insurance), while in previous periods it was limited to regional provision.

From January 1st 2008 on, the medical component of mental health care is transferred to the health care sector, at least for the first year of care; 75% of mental health care budget currently goes to the field of the ZVW[wwwwww]. After one year, reimbursement is transferred to the domain of AWBZ; about 25% of mental health care budget currently still belongs to the responsibility of the AWBZ. Social support still remains limited to 2% of the mental health care budget (it should be noted that it is difficult to know if this budget is spent to social support of persons with mental disorders, since the budgets transferred to the municipalities are not earmarked). At the same time, DBC's are introduced in mental health care (see further).

In principle, specialist mental health care including ambulatory consultations of psychiatrists, is only accessible to people referred by their GP. In both acute and crisis situations, secondary level mental health services can be contacted directly. According to Trimbos, an evolution towards a more intensive collaboration between the first and second mental health care line can be noted, (partly) due to specific governmental stimuli. However, this has not diminished the amount of referrals to secondary care (cfr Trimbos Trendrapportage GGZ 2008 p127)[207]. As from 1st January 2008, psychologists can provide *first* line psychological help and this is considered to belong to the insured standard benefits package [xxxxxx] that also includes e.g. consultations by general practitioners (see further).

Because the recently introduced market-oriented principles require that every citizen should be able to compare[yyyyyy] different care organizations, efforts are put in the development of *performance indicators*, e.g. the existence of (long) waiting lists[zzzzzz]. No information on a generally applicable system could be found. Specific programs on quality evaluation are also being developed (e.g. the KRAS project on schizophrenia care by the Trimbos institute).

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wwwwww http://www.minvws.nl/kamerstukken/cz/2008/aanbieding-van-de-trendrapportage-ggz-2008.asp
xxxxxx www.nza.nl
yyyyyy http://www.kiesbeter.nl/zorgverleners/
zzzzzz http://www.ggznederland.nl/index.php?p=11685 2

9.4.4 Scientific institutes, Knowledge centers for mental disorders

The Trimbos institute[aaaaaaa] is a national institute in charge of the development of new treatments, guidelines and prevention programs in mental health. It is also responsible for evaluation of the Dutch mental health care system, including effectiveness, quality and accessibility; and it has the responsibility to inform the Dutch Government on these subjects. It is in charge of education and support of mental health care professionals.

ZONMw[bbbbbbb], the Dutch Organization for health research and development, is a national organization that promotes quality and innovation in the field of health research and health care, initiating and funding new developments. ZonMw also actively promotes knowledge transfer and implementation. ZonMw acts as an intermediary between policy, research and practice. It has a specific subdivision for mental health care.

"Knowledge centers" are centers comprising one or more mental health care organization as well as research centers such as university hospitals or the Trimbos institute. Together they aim at providing specialized information on a specific target group of patients to other professional institutions, and they aim at organizing research. Many different "Knowledge centers" for mental health care exist[ccccccc], e.g. a knowledge centre for bipolar disorders, schizophrenia, elderly persons, autism, informal care giving etc. The Knowledge centers are centralized on the national level in the "Landelijk netwerk kenniscentra GGZ". In 2003, 7 knowledge centers were officially recognized and subsidized by the Government (Brancherapport GGZ 2000-2003, Trimbos).

9.4.5 Mapping of existing services

9.4.5.1 A Dutch definition of residential, partial/mixed residential and ambulatory care

As a preliminary remark, it is interesting to note that the GGZ Nederland[ddddddd] (an organisation of Dutch mental health care providers) has developed operational definitions to classify clients as ambulatory, partially residential or residential.

- Residential clients: when clinical inpatient care takes 90% or more of the total care
- Partial residential care: if clients receive less than 90% clinical care
- Mixed residential: if clients receive less than 90% clinical care and if the client receives any other form of support.
- Ambulatory: care outside the clinical facilities.

The main characteristic of this definition is that the demand side, and not the supply side, is taken as a reference point.

9.4.5.2 The "Service Tree" in the Netherlands: (still) integrated mental health care facilities.

In the description of the other countries, we use the 'Service Tree' developed by Johnson et al. to map the mental health services[5]. This 'Tree' is presented in the Table below.

A table with an overview of available services in the Netherlands is presented in chapter 14.1.6.

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aaaaaaa http://www.trimbos.nl/
bbbbbbb http://www.zonmw.nl/nl/
ccccccc http://www.trimbos.nl/ggz-adressen/kenniscentra
ddddddd http://www.ggznederland.nl/

Table: Synthetic presentation of the ESMS tree

SECURE **(1)**			
RESIDENTIAL	Generic acute	Hospital **(2)**	
		Non-hospital **(3)**	
	Non-acute	Hospital **(4)**	Time limited **(4.1)**
			Indefinite stay **(4.2)**
		Non-hospital **(5)**	Time limited **(5.1)**
			Indefinite stay **(5.2)**
DAY & STRUCTURED ACTIVITY	Acute **(6)**		
	Non-acute **(7)**	High intensity **(7.1)**	
		Low intensity **(7.2)**	
OUT-PATIENT & COMMUNITY	Emergency care **(8)**	Mobile **(8.1)**	
		Non-mobile **(8.2)**	
	Continuing care **(9)**	Mobile **(9.1)**	
		Non-mobile **(9.2)**	
SELF-HELP & NON-PROFESSIONAL **(10)**			

However, as already mentioned, the Dutch mental health care model used till recently to a certain extent a different organisation typology[eeeeeee].

During the 1990's, in most of the Dutch regions, psychiatric hospitals, Riaggs (see infra) and other types of care provision merged into so-called "integrated mental health care facilities". These "integrated mental health care facilities" offer a spectrum of services in ambulatory, residential or semi-residential form. No specific information is readily available e.g. on the total number of places in semi-residential care, which makes it impossible to use the "Service Tree".

Nevertheless, some general information on the distinctive care settings in the Netherlands is available in the Table 9.1. (Note that the Netherlands have a population of about 16 million inhabitants). Even though the most recent reformations (see above) without doubt will influence the organizational system and change it again, the current situation is still largely influenced by the existence of "integrated mental health care facilities".

Table 9.1 Number and type of Mental Health Care Organizations (GGZ-instellingen), 2000-2005

	2000	**2001**	**2002**	**2003**	**2004**	**2005**
Integrated mental health care facilities*	30	32	35	39	41	40
Psychiatric hospitals (APZ, Algemeen psychiatrische ziekenhuizen)	12	10	8	5	3	3
RIAGG	19	15	12	12	10	9
RIBW	26	24	24	23	21	21
Facilities for child and adolescent psychiatry	10	10	10	10	10	10
Integrated facilities for addiction care	12	12	11	9	8	9
Facilities for ambulatory addiction care	8	8	9	9	6	4
Forensic psychiatric centres (TBS "Ter Beschikking Stelling")(Dep. Justice)	7	7	7	7	7	7
Total	**124**	**118**	**116**	**114**	**106**	**103**
Source: Leden Administratie GGZ Nederland 2006						

PS. *Additionally, independent psychiatric departments are found in 40 general hospitals in 2006 (Trendrapportage 2008 Part 2 p7)[207].

eeeeeee http://www.ggznederland.nl/index.php?p=115302 (in Dutch)

A general distribution of ambulatory, semi-residential and residential care for the different care circuits is also available (Table 9.2). This should be read cautiously: all types of care, also ambulatory short-term care are included, for which no numbers are mentioned in the description of several other countries.

Tabel 9.2 Care type for each circuit (including integrated mental health care facilities, psychiatric hospitals (APZ), RIAGGs***, RIBW and child- and adolescent psychiatry), 2006, in%.**

	Children and adolescents	Adults	Elderly	Sheltered Living*	Total
Ambulatory	96	86	88	46	88
Part-time	1	2	2	0	2
Residential	2	8	7	53	7
Mixed residential	1	4	3	1	3
Total	**100**	**100**	**100**	**100**	**100**

Source: Trimbos Trendrapportage2008 part 2 (p 25)[207]
*In independent RIBWs or in RIBWs within integrated care facilities
**PAAZ (psychiatric departments of general hospitals not belonging to integrated mental health care facilities) are not included.
***Consultations of independently working psychiatrists and psychologists are not included; GP consultations are not included.

Although for the Netherlands it impossible to use the "Service Tree", in the next paragraph some additional information will be given for some types of services, for which this is necessary to understand properly the Dutch situation.

9.4.5.3 Inpatient services

Official numbers estimate that in 2007 in the Netherlands 13.7 psychiatric beds were available per 10 000 population[fffffff]. This number does not differentiate between hospital beds in integrated care facilities; beds in psychiatric hospitals; or psychiatric services in general hospitals. The number is among the highest in Europe. The residential mental health care capacity stabilized in the 1990's, but since the beginning of the new century, there is again an increase (Trendrapportage 2008 Part 1)[207]. From 1993-2006 there was a net stabilization of the residential capacity taking into account the population growth; so no "deinstitutionalization" took place. When the Sheltered housing schemes (see further) are included as well, the residential care and housing services currently take about 50% of the total mental health care budget[ggggggg].

The Trimbos institute estimates that this is caused by several influences. First of all, these "residential beds" include several types of service provision, which are not always true residential care, but which for administrative reasons are coded under "residential". Secondly, the fact that for a long time mental health care, although internally integrated, had an isolated position in the society and was poorly integrated in other cure and care service provisions ("verkokering"), made it necessary to establish housing schemes within the mental health care circuit as well.

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fffffff HFA-Database (http://data.euro.who.int/hfadb/) shows 134 Dutch Psychiatric hospital beds per 100000 in 2004 and 137 in 2007. HFA-DB definitions are World Health Organization Definitions harmonized with EUROSTAT and OECD in 2006: Psychiatric care beds in hospitals (HP.1) are hospital beds accommodating patients with mental health problems (part of HC.1 in the SHA classification). Inclusion - All beds in mental health and substance abuse hospitals (HP.1.2). - Beds in psychiatric departments of general hospitals (HP.1.1) and of speciality (other than mental health and substance abuse) hospitals (HP.1.3). Exclusion - Beds allocated to non-mental curative care (part of HC.1). - Beds allocated to long-term nursing care in hospitals (HC.3). - Beds for rehabilitation (HC.2). The data cover beds in mental hospitals and, since 1990, includes beds in psychiatric departments of general hospitals. Statistics Netherlands: Statistics of intramural health care. Beds in university hospitals excluded as from 2002 onwards.

ggggggg http://www.minvws.nl/kamerstukken/cz/2008/aanbieding-van-de-trendrapportage-ggz-2008.asp

Nevertheless, the currently existing housing facilities for persons with mental disorders are largely "deconcentrated" and often organized in small living units, not resembling anymore the ancient asylums. Finally, according to Trimbos, the stable and infinite AWBZ resources (provided care would be reimbursed anyway), the fact that politicians did not put forward firm goals for deinstitutionalization, and the high number of e.g. psychiatric nurses in the Netherlands, might have had an influence as well.

Psychiatric hospitals

The Dutch "psychiatric hospital" (PH) (in 2005, only 3 independent PH were left) encompasses a very wide range of services that are not all residential, the "integrated mental health care facilities" alike. Psychiatric hospitals have admission wards and specialized units for groups with special needs (e.g. people with addiction problems), psycho-geriatric departments for the elderly; but they also developed outpatient clinics, day centres, housing units for long-term residents, therapeutic communities, intensive home care, outreach activities.

Psychiatric wards in general hospitals

General hospitals can have a psychiatric department for (acute) psychiatric treatment (PAAZ). After the merging of different mental health care organisations a vast majority of these psychiatric wards of general hospitals became part of integrated mental health care organisations. In 2006, about 40 independent PAAZ existed.

Regional institutes for Sheltered housing schemes

RIBW (Regionale Instelling voor Beschermende Woonvormen), or the "integrated mental health care facilities" they belong to, organise different forms of staffed living facilities. Different forms of housing facilities are offered, varying from individual to group facilities. In 2006, 10.225 places were available or 64 places/100.000 population (Trendrapportage 2008 part 1 p66; part 2 p59)[207]. There were 74 users/100.000 population in 2004. However, RIBW also offer different forms and models of independent living support & coaching[hhhhhhh] for people living alone[iiiiii]. They also offer day activities and are in charge of help to those who want to go back to work (see further).

Many of the RIBW fused with one of the large integrated mental health care facilities.

Psychiatric nursing facilities

Psycho-geriatric nursing-homes are in particular oriented on the old age population.

Forensic psychiatry

A special "care circuit forensic psychiatry" is developed for persons with a mental illness having committed a criminal offence. Care programs aims at treating the disorder of the client and protecting society for other offences. They contain a wide range of services, from a stay in a closed ward to supervised forms of independent living. It always holds obligatory mental treatment.

Three types of inpatient services are distinguished:

- forensic psychiatric centres (FPC) for people under terbeschikkingsstelling (tbs) (the heaviest profiles) These facilities are generally highly protected.
- forensic psychiatric hospitals (FPK)
- forensic psychiatric departments (FPA) with closed and open units. Treatment in FPA is generally shorter than in FPK.

FPC is generally fully under the responsibility of the department of Justice; FPK and FPA are part of the regular mental health care (although they are funded through the justice department). Because of the problems of continuity of care, forensic policlinics have been created, as part of the forensic circuits.

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hhhhhhh http://www.ribwalliantie.nl/default.asp?p=wb&m=menu_Woonbegeleiding

iiiiii http://www.ribwalliantie.nl/ (Dutch)

9.4.5.4 Ambulatory services

Most of these services also belong to the "integrated mental health care facilities"; some services remained independent (see Table 9.1 in chapter 9.4.5.2)

Regional institutes for ambulatory mental health

Riaggs (Regionaal Instituut voor Ambulante geestelijke gezondheidszorg) offer a broad spectrum of services from curative psychotherapy to supportive community psychiatric care for different age groups (children, adults elderly). They have the responsibility to organize a permanent outreach crisis service. The Trendrapportage 2008 (part 2 p 57-59)[207] mentions 4100 users/100.000 population (20-64 years) or 5427 users/100.000 population (+18 years) of ambulatory care in 2004 (RIAGGs and out-patient clinics included, independently working psychiatrists or psychologists are not included).

Regional institutes for sheltered housing schemes

RIBW (Regionale Instelling voor Beschermende Woonvormen, see higher), or the "integrated mental health care facilities" they belong to, offer different forms and models of independent living support & coaching[jjjjjjj] for people living alone[kkkkkkk], in which case therapeutic medical care is not offered. More and more outreach teams are developed to support clients living in regular housing. They also offer day activities and are in charge of help to those who want to go back to work. However, no information on the number of vocational rehabilitation services or programs for supported work is available (cfr Trimbos Trendrapportage GGZ 2008 p76).

Day hospitalization (Partial hospitalization)

Partial hospitalization places are developed as alternatives to full time-hospitalizations. It are mainly day-hospitalisations in psychiatric departments of general hospitals. In 2005 there were 5124 places for part-time hospitalization (over-all population, Trendrapportage 2008 part 1 p75); this is approximately 32 places/100.000 population. This means an increase by 300% since 1980. Part-time hospitalization or other forms of part-time treatment were used by 230 adults (20-64 years) in 2004 (Trendrapportage 2008 part 2 p60)[207].

Day care

Day care facilities are developed in the framework of RIBW[lllllll]. Activities can be oriented towards structured day activities or voluntary work adapted to the condition of the patient. Most of these day care centres are an integrated part of other mental health care organisations. The use of day care centres is most of the time integrated in the programmes of long term care. No precise numbers of capacity or users of these services were found; according to the Trendrapportage 2008 there were 125 day centres and about 100 services for vocational rehabilitation in 1998.

Rehabilitation centres

Several forms of rehabilitation services have been developed during the 1990's, including consumer run self help projects (e.g. work, restaurants, buddy projects, club houses, sporting groups, day meeting centres, information and help desks etc.

Independently working mental health care providers

To the independently working mental health care providers belong psychiatrists (second line health care professionals), and psychologists (first line health care professionals). In 2005, there were 2487 practisizing psychiatrists in the Netherlands, or 15.5/100.000 population (Trendrapportage 2008 part 1 p56)[207]. No further information of the subgroup of independently working psychiatrists, or on their activities was found. Trendrapportage does not comment on the number of psychologists, because many are working in other sectors than mental health care.

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jjjjjjj http://www.ribwalliantie.nl/default.asp?p=wb&m=menu_Woonbegeleiding

kkkkkkk http://www.ribwalliantie.nl/ (Dutch)

lllllll http://www.ribwalliantie.nl/default.asp?p=dw&m=menu_Dagbesteding%20&%20werken (Dutch)

9.5 FINANCING OF MENTAL HEALTH CARE

9.5.1 Global data

According to the WHO, about 7% of the Dutch health care spending is used for mental health care (2005)[mmmmmmm].

According to CBS estimates (Trendrapportage Trimbos, 2008 part 1 p80)[207] specialised mental health care accounted in 2007 for 6,1% of all health care costs[nnnnnnn]. The public expenditures for mental health care have increased in the years 1998-2007 (99%), even more than the increased expenditure in general health care (81%). In 2005 intramural facilities and facilities for sheltered living accounted for 56% of the mental health care budget (the former for 45%, the latter for 10%); and part-time or day care treatment for 12%. Ambulatory care accounted for 32%, of which about 1% is for independently working psychiatrists; GPs and psychologists in primary care are not included.

Some regional differences are described, as some provinces spend relatively more on ambulatory care provision, and others more on residential forms of care. These differences are not explained by epidemiological factors, but mainly through historical factors.

9.5.2 Data per sector of activities

Until the reforms of 2006 the mental health care sector was identified as rather homogenous with an earmarked budgeting through the AWBZ (see 9.4.3). The Trendrapportage GGZ 2008 hypothesizes that the earmarked and clearly identified financing of mental health care is probably an important factor that contributed to the development of an identifiable and integrated health care sector.

However, criticisms had grown, mainly because mental health care services were integrated with other mental health care services but not with regular cure and care service provisions for other disorders ("verkokering"). This led to an isolated position of mental health cure and care, and also of its patients; and it also gave the large care providers (too) much influence and the patients too little freedom of choice. Moreover, it was felt that the "treatment" of mental disorders belongs to the field of medical care and the ZVW, and it was stressed that this type of care often does not correspond to the field of AWBZ. At the same time, in the ZVW large reforms had started under the credo "Less government, more market", and it was hoped that the same reforms in the field of mental health care would lead to more efficiency and less costs.

The most recent policy reforms in the Dutch mental health care system date from 2006, and take as a starting point that mental health care should be part of a network of other (health) care and welfare facilities.

As a consequence of these reforms, as of January the 1st 2008, the medical component of mental health care and 75% of the former mental health care budget has been transferred from the public AWBZ to the private sector of ZVW; and first line and specialist medical secondary line is funded and reimbursed within the framework of the ZVW (zorgverzekeringswet). After one year, the patients will again fall under the AWBZ regime, and about 25% of the mental health care budget still belongs to the responsibility of the AWBZ. The funding of forensic care has been transferred to the justice department.

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mmmmmmm http://www.who.int/mental_health/evidence/mhatlas05/en/index.html

nnnnnnn This includes expenditure for psychiatric consultations outside the care facilities, and of psychotherapist consultations, which each account for 1% of the total mental health care budget.

For hospital and specialist mental health care under the ZVW, an adapted DRG funding system ("diagnose-behandel combinaties", DBC's) has been introduced (http://www.dbconderhoud.nl/). As from 1st January 2008, psychologists can provide first line psychological help and this is considered to belong to the insured standard benefits package that also includes e.g. consultations by general practitioners; for this type of service no DBC has to be registered. Even so for care that is considered to fall under the AWBZ, no DBC has to be registered[oooooo].

Each DBC describes the trajectory of care and the related activities based on the needs of the patient. Based on these trajectory related activities and interventions, the cost are estimated. The costs are estimated on the number and hours of interventions and the staff needed. So far, if finally the number of hours or interventions exceeds the estimated number, the difference is adjusted for. This leads to the informal critics that the DBC system in fact is a fee-for-service system.

The DBC logic has integrated the clinical (intramural) and ambularory interventions in one common model[ppppppp], but distinguishes "verblijfsgroepen" (residential groups) from "behandelgroepen" (treatment groups) for setting the tariffs. No specific identification for multidisciplinary acts exists yet. Currently there are 145 treatment groups (based on the DSM-IV categories) and 70 residential groups. The implementation of the DBC in mental health care (and other care) has not been easy. It is at this stage too early to assess the impact of the new financing regime.

Within AWBZ the financing is based on "intensity of care" (zorgzwaartefinanciering) since January 1st 2008. The financing principles will be based on the needs of the clients, replacing an average funding per bed. Different "intensity of care packages" (zorgzwaartepaketten) for mental health care have been identified[qqqqqqq]

The provision of support under the WMO (as from 2007), is expected to contribute a small fraction of the budget to persons with mental disorders. However it is expected that in the future this fraction of WMO budget for mental health care could increase, as many local policy makers were not ready to provide the necessary support for persons with mental health care problems (especially for the part of providing day-care and autonomous living arrangements). A first preliminary report of this shift offers indications that the transfer of AWBZ activities to WMO activities is quite a difficult issue (Trendrapportage 2008 GGZ)[207]

In 2009 the Minister announced his intention to lower tariffs for mental health treatment by 3.5 percent next year, because GGZ members overspent by EUR 185 million in 2008. Lower tariffs would mean less income for the GGZ member institutions.

[oooooo] http://www.dbcggz.nl/website/faq.asp?id=50&command=detail&questionid=25&questionnr=9

[ppppppp] http://www.dbcggz.nl/cms/data/attachments/505/bestand/Productstructuur%202008.pdf

[qqqqqqq] http://www.minvws.nl/kamerstukken/lz/2006/voortgangsrapportage-zorgzwaartefinanciering-2.asp

9.6 ADVANTAGES/DISADVANTAGES OF THE DUTCH MENTAL HEALTH CARE ORGANIZATION

- The Netherlands are clearly ahead in the creation and establishment of care programs, since already in the 1990's they emphasized the importance of continuity of care. Currently 60% of the mental health services use Care programs. However, no official documents were found on the quality of these care programs, their outcome (do they increase efficiency and/or quality of care?), nor on their appreciation by patients and care providers.
- The Netherlands are also ahead in providing integrated mental health care circuits in large, fused care companies. This might have (partly) been facilitated by the uniform funding system (the AWBZ). A possible drawback is that it might not be easy to get information on the availability of some specific types of care provision, e.g. work-related rehabilitation, partly because the way it is organized might differ from one care provider to another.
- Notwithstanding its advantages, the integrated care circuits have been criticized for not providing enough choice to their patients, and for being not open enough to the rest of the society ("kokerzorg"). So the system has to change again, and recently new financial stimuli were created aiming at optimizing the system. E.g. a certain amount of money goes directly to the municipalities, who should be able to coordinate and provide social support directly in the community for all types of social needs. However, since this budget is not earmarked, it will depend on each municipality whether they estimate that persons with mental disorders need the money the most (or not). According to Trimbos, regional inequalities might arise.
- As from January 1st 2008, 75% of the mental health care budget falls under the responsibility of the ZVW (Zorgverzekeringswet). The recent market-oriented development of the ZVW uses a DRG-like system (DBC's) for its funding, which are based on DSM-IV categories and represent actually a certain type of fee-for-service system since professionals are paid for a number of minutes of care provision. The market-oriented system should regulate excesses. Whereas indirect care (no direct care with the patient, e.g. writing reports) is counted separately, no specific item for multidisciplinary consultation so far exists.
- However, the system, including the DBC system, appears to be quite complicated and difficult to implement. This led already to the informal use of a new word, "care in the office" ("kantoorzorg"), since the administrative burden seems to take so much time that less time is left for contact with patients.
- After one year, patients fall under the responsibility of the AWBZ. The AWBZ has an independent agency responsible for indication setting (CIZ); its funding is based on functioning of the disabled person and the reimbursement is adjusted to the intensity of care that has to be provided (zorgzwaartefinanciering). This is much the Flemish VAPH (Vlaams agentschap voor personen met een handicap) alike, but the VAPH is not competent for reimbursement of persons disabled because of a mental disorder (except for persons with a congenital mental disorder, mainly autism). Rather, the Belgian federal NIHDI (National institute for health and disability insurance, RIZIV/INAMI) is in charge of a large part of this care. The Dutch AWBZ funding system so far has not been officially been evaluated on its merits and its weaknesses.

- The Trimbos institute is quite critical for the reformations of the last few years, and especially concerning cure and care for persons with severe and persistent mental disorders. Trimbos fears that the market-oriented system will somehow invest less in care needs of these persons, because it is complex and therefore not easy to manage. Also, the market- and for-profit-principle might disturb the sense of collaboration that currently exists. On the other hand, the budget for the AWBZ will diminish, and the WMO budget is not earmarked.
- From 1993-2006 there was a net stabilization of the residential capacity taking into account the population growth; so no real "deinstitutionalization" took place (for Trimbos interpretation, see before). Rather a "deconcentration" took place, i.e. an evolution to different types of small-scale housing initiatives instead of the large asylums.
- In the Netherlands, general practitioners are the gatekeepers to specialized mental health care (except for urgencies). According to Trimbos, an evolution towards a more intensive collaboration between the first and second mental health care line can be noted, (partly) due to specific governmental stimuli. However, this has not diminished the amount of referrals to secondary care. (cfr Trimbos Trendrapportage GGZ 2008 p127)[207]. Psychologists can provide first line psychological help and this is considered to belong to the insured standard benefits package of the ZVW.
- Care improvement and knowledge dissemination is stimulated by the Government by the funding of scientific institutes and knowledge centers. Performance indicators are under development.

10 SPAIN

10.1 LITERATURE SEARCH: METHODOLOGY

See general methodology. No information (references, data…) has been included after August 31, 2009.

10.2 ORGANIZATION AND FINANCING OF THE HEALTH CARE SECTOR[rrrrrrr]

The level of health care coverage is nearly universal in Spain. After the introduction of the NHS in 1986, the eligibility is increased to cover most of the population. By 1997, it was estimated that 99,7 % of the population was covered by the statutory system: 94,8 % of the population was covered by a obligatory affiliation to the social security system, the vulnerable and disadvantaged were subject to separate administrative regulations and the remaining 4,6 % of the population (2 000 000 people) were covered through three non-profit mutual funds (Social Institute for the Armed Forces – ISFAS, the General Legal Mutual Company – MUGEJU and the Mutual Fund for State Civil Servants – MUFACE)[209].

10.2.1 Organizational overview of the health care system

In 2009, it was estimated that Spain had about 46.6 million inhabitants[sssssss]. The political organization of the Spanish state is made up of the central state and 17 highly decentralized regions (Autonomous Communities, AC) with their respective governments and parliaments. Central government has the responsibility for promoting coordination and cooperation in the health sector. From 1986, the transition to a National Health system (NHS) has transformed the financing system into a system based on taxes with almost universal coverage. The decentralization was completed in 2003 and resulted in 17 ACs being responsible for provision and financing of health care in their territories.

10.2.1.1 The role of the central government

The central government in Spain assumes responsibility for certain strategic areas, including (Duran, 2006, p. 21)[208]:

- general coordination and basic health legislation;
- financing of the system, and regulating the financial aspects of social security;
- definition of a benefits package guaranteed by the NHS;
- international health;
- pharmaceutical policy;
- undergraduate education and postgraduate medical training;
- civil service-related human resources policies.

10.2.1.2 The role of regional governments

Each region holds health planning power as well as the capacity to organize its own health services to the level of decentralization that it considers most appropriate. Since 2001, the co-responsibility between the central state and the regions has increased and since January 2002, all regions have received the same management power within the National health system.

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rrrrrrr We base this section on the report on the Spanish health care system 'health System in Transition' N°4 (2006) [208]

sssssss http://www.ine.es/prensa/np551.pdf

10.2.1.3 Health areas

According to the 1986 General Health Care Act, health areas are defined according to geography, socioeconomic standards, demography, employment, epidemiological factors, cultural concerns, transportation and the existing health facilities. Each health area, responsible for the management of facilities, benefits and health service programs within its geographical limits, should cover a population of no fewer than 200 000 inhabitants and no more than 250 000. Both primary health care and specialized care services are provided in the health areas. Primary health care is defined as care of individuals, families and the community at large through health promotion programs, prevention, curative care, and rehabilitation. Within specialized (outpatient and inpatient) care, each health area is linked to, or has, at least one general hospital. Specialized ambulatory care is provided through an integrated public network, which is dependent on hospitals, and in some cases staffed with the same teams (with members who rotate to cover ambulatory visits).

10.2.1.4 Basic health zones

Basic health zones are the smallest units of the organizational structure of health care. Each is defined in accordance with the degree of concentration of the population, the epidemiological characteristics, and the facilities and health resources of the area. A maximum distance of 30 minutes between communities and the location of services, as standard traveling time, gives rise to basic health zones covering between 5000 and 25 000 inhabitants. They are usually organized around a single primary care team, which is also the main management unit of the zone, coordinating prevention, promotion, treatment and community care activities. 2498 basic health zones have been designed, within which the resources of PHC are organized and the corresponding health centers deliver care to the local population. The leader (termed "coordinator") of the EAP (Primary care team) reports to the area manager while simultaneously holding a direct line of accountability to regional government authorities (which reflects the limited managerial autonomy given to health care areas). The governance structure in hospitals is made up of a medical division, a nursing division and an administrative division, all hierarchically subordinated to the general manager, who directly reports to the corresponding regional authorities. This management system was created through central legislation during the 1980s. The autonomous communities, however, are free to modify this organizational model, and to choose a higher or lower degree of decentralization of power within their respective territories.

10.2.2 Financing of the health care sector

In the mid-1970s, the social security system covered about two thirds of the total health care expenditure. The transition to a National health system (NHS), initiated in 1986, led to an important shift from the social security to contributions of the State. The new model of financing was adopted in 2001 with two main sources for the Autonomous Communities (ACs): taxes and allocations from the central government. Private health care financing consists of three complementary sources of finance: out-of-pocket payments to the public system, out-of-pocket payments to the private sector and voluntary health insurance[208].

Table 10.1: Sources of revenue as a percentage of total expenditure on health (comparison 1991 – 2003). Source: European Observatory[208]

Source of revenue	1991	2003
Public	**77.5**	**71.2**
Government (central + regional) excluding social security funds	55.7	65.9
Social security funds	21.8	5.3
Private sector	**22.5**	**28.9**
Private insurance enterprises (other than social insurance)	2.9	4.3
Private household out-of-pocket expenditure	18.7	23.7
All other private funds	0.9	0.8

Health care expenditures accounted for approximately 8,3 % of the GDP in 2005. 71,2 % of total health care expenditure is publicly funded, of which taxation accounts for 98 %, while private expenditure through user charges is approximately 24 % and private insurance just 4 % of the total health care expenditure (OCDE ECO HEALTH 2007 and Salvador-Carulla et. al. 2006[209]). Out of pocket spending makes up the most important part of the private spending[210] with a proportion of 74 %.

92,2 % of the total public health expenditure (estimation for 2006: 46,400 Million euro) is directly managed by the ACs. The complement is represented by transferred funds from the central government to the ACs[209].

Key points

- **The Spanish system is a NHS-type system for which funding is largely provided by taxes and allocations from the central government. However, private financing is also provided by out-of-pocket payments and voluntary complementary insurance.**
- **Mapping of mental health care supply is organized on a "basic health zones" system (5000-25 000 inhabitants). Each basic health zone is organized around a primary care team.**
- **The basic health zones belong to a larger Health area (200 000 to 250 000 inhabitants) that is responsible for both primary and specialized health care and has at least one general hospital.**
- **Given the Spanish institutional and political structure, practical organization of psychiatric care also depends on the 17 highly decentralized regions or AC's ("Autonomous Communities").**
- **92 % of the total public health expenditure is directly managed by the AC's. The rest are funds transferred from the central government to the AC's.**

10.3 ORGANIZATION OF THE MENTAL HEALTH CARE IN SPAIN

Mental health care has traditionally been one of the most neglected aspects of the Spanish health system. Historically there has been a pronounced over reliance on hospitalization for chronic psychiatric cases, inadequate provision of outpatient care and a notable lack of social health care resources. The system was characterized by an excess of division of responsibility for services among various public administration bodies and a lack of coordination among parallel networks providing care in this field. In the 1970s, several mental health care teams in some provinces began to promote on their own initiative a community-centred approach to mental health care, creating special units in contrast with the existing psychiatric hospital-centred mental health network (Duran, 2006, pp. 139-140)[208].

10.3.1 The 'psychiatric reform'

The Spanish 'psychiatric reform' presents a specific profile because it coincided with the democratic transition that took place in the country in the 1970s and 1980s.

Following Pinto 2002 (pp. 24-25), the conceptual bases of the reform can be summarized as follows[211]:

- to guarantee attention to mentally ill patients within the general network of health care and especially in primary care services;
- to redefine the therapeutic meaning of psychiatric hospitalization, which lost its central role in psychiatric care, and was located in general hospitals
- to provide adequate community services and social support to make it possible to rehabilitate and resettle psychiatric patients in society
- to bring about changes in the community to prevent the marginalization of these patients
- to guarantee the civil rights of persons with mental disorders

Considering these aims, the closure of mental hospitals had to be considered as the consequence of the changes advocated in psychiatric care. Between 1982 and 1985, number of initiatives was taken by the central government and by the autonomous communities. In 1983, the Commission on psychiatric reform was created and in April, 1985 a report establishing the conceptual bases of the reform was edited. The General Health Care Act (1986) confirmed that mental patients should be treated as users of worth equal the rest of the population.

10.3.2 General principles

In accordance with the principles of the Spanish General Law on Health, the psychiatric services should be organized according to the 'Health Areas' covering between 200 000 and 250 000 inhabitants[tttttt]. They should also provide a fully integrated mental health care per area.

Access to psychiatric services should be through primary care units, with the specialized levels of care based on community mental health centres. Hospitalization, which is now considered merely one more instrument in the therapeutic process, should be provided by general hospitals. Also considered of specials importance is the need to complement psychiatric care by providing sufficient "intermediate" community services (day hospitals, day centres, units of psychosocial rehabilitation, sheltered accommodations,…). The plan was that all these resources should constitute a functional unit that will allow an *integrated* approach to the treatment and rehabilitation of patients and to the prevention of mental illness.

10.3.2.1 Hospital care

The reduction in the number of beds in psychiatric hospitals varied considerably among the different autonomous communities. Initially, only a few general hospitals had psychiatric units. However, after 1986, following the recommendations of the commission's report on Psychiatric Reform, there was a significant increase in the number of these units, which started to assume responsibility for the acute inpatient care of mental illness. In 1990, there were 74 such units with a total of 1,784 beds, and in 1995 there were 105 units with 2,401 beds; since 1995 this reduction has slowed down (Vazquez-Barquero 2001)[212]. Also, the number of psychiatrists increased significantly during the Psychiatric Reform and reached 2,016 in 1994 (5.1 per 100,000 inhabitants). Again, there are marked differences between the different autonomous communities. The number of psychologists has risen even more and the same is true for qualified nurses (Ministerio de Sanidad, 1999).

10.3.2.2 Primary care

Extending mental health care to primary care has been one of the mainstays of the Psychiatric Reform. The referral rates from primary to specialized care are around 11 percent and the capacity to provide treatment is 89 percent, which shows the importance of the role played by primary care in mental illness. While the integration of mental health care in primary care generally has been considered to be beneficial, questions have been raised as to the difficulty that general health professionals tend to have in understanding some specific aspects of mental illness and its treatment (e.g. treatment not belonging to the traditional medical-biological model) (Vazquez-Barquero 2001)[212].

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tttttt We base this section on the work of Pinto 2002 [211].

10.3.2.3 Secondary care in the community

Mental health centers or teams, created following the criteria of territorial distribution and decentralization, are the cornerstone of the specialized mental health care. They have experienced the greatest growth due to the Psychiatric Reform (see Appendix to chapter …). They all have a minimum basic staff consisting of a psychiatrist, a psychologist, a qualified nurse, and a person to perform administrative duties. Notwithstanding this, they are distributed unevenly throughout the country and their resources also vary considerably from one AC to another. In 1996, 555 mental health centers existed (477 in 1991) with an average coverage rate of 70 757 inhabitants per centre (79 061 in 1991) and a utilization rate of 92 annual visits per 1 000 inhabitants (53 in 1991) (Duran, 2006, pp. 143-144)[208]. There has also been a clear change in the pattern of use of these mental health services, with an increase in the demand concerning minor psychiatric disorders and a greater similarity in the socio-demographic characteristics between users of these services and users of the other medical specialties.

10.3.2.4 Intermediate care services

The health reform has included the transfer of some services for people with mental disorders and for those with intellectual disabilities out of the health sector and usually to the social care sector. Such service transfers include non-hospital residential care, occupational care and other intermediate care facilities. These "intermediate" community services have been developed, but this happened to a greater extent precisely in those communities which have taken de-institutionalization and the closure of psychiatric hospitals furthest. Also, it has been observed that the most important difficulty of the "psychiatric reform" has been the development of intermediate community services and programs to rehabilitate and resettle patients in the community (Vazquez-Barquero 2001)[212]. As a consequence of this, at the end of the 1990s about 90% of mentally ill patients in Granada or Santander were living with their families (as compared to about 50% in England, the Netherlands and Denmark). Although there might be many other causes for this phenomenon as well, this situation generates high levels of family burden that, according to Vazquez-Barquero et al, are not compensated by appropriate family support programs.

10.3.2.5 Conclusion

It can be concluded that the 'psychiatric reform' initiated since the 1980s has produced significant achievements (Pinto, 2002, p. 24)[211]:

- the development of a new organizational structure for mental health care, decentralized in character and territorially based;
- the integration of psychiatric patients in the general health care system, reflected through the involvement of primary care services in their management and in new forms of hospitalization in general hospitals;
- the creation of an extensive community network of mental health centres;
- adoption by the general public of more positive attitudes towards mental illness and its treatment, and the adoption of legislative measures aimed at improving the civil rights of these patients.

All this has meant a new way of understanding mental illness and its management, in which the emphasis is placed on "normalizing" the care of the patient and the relationship between patient and society. This concept of "normalization" is essential since it attempts to overcome the "special status" that previously characterized mental illness in the Spanish health system.

Nevertheless, differences in the implementation of the reform between autonomous communities are observed. Whereas psychiatric beds in general hospitals as well as mental health centres in the community are known to be distributed unevenly, the most important difficulty is the development of intermediate community services and programs to rehabilitate and resettle patients in the community. Strong tendency to maintain the old mental hospital is still observed and, if the concept of deinstitutionalization is accepted by a majority, the inadequate implementation is criticized (Vazquez-Barquero 2001).

10.3.3 Mental health indicators: heterogeneity between Autonomous Communities

A limited comparison of the mental health care between ACs and the national and European levels were made by Salvador-Carulla et. al. in 2006. This exercise, illustrated by the following table, shows a remarkable heterogeneity between the regions.

Table10.2: Mental Health Care Indicators in Europe, Spain and four Autonomous Communities: Rate of psychiatric beds per 10,000 inhabitants and of mental health professionals par 100,000 inhabitants (Source: Salvador-Carulla et. al. 2006, p. 38 [209])

	Europe	Spain	Catalonia	Andalucia	Madrid	Navarre
Total Psychiatric beds	8.7	4.4	8.3	3.35	2.95	5.13
Psych beds in Psych hospitals	NA	3.7	6.57	0.04	1.94	0.92
Psych beds in general hospitals	NA	0.6	0.76	0.75	0.58	0.97
Psychiatrists	9.00	3.6	7.06	5.29	NA	6.71
Psychologists	3.00	1.9	4.90	2.51	NA	4.95
Nurses	27.5	4.2	5.75	6.02	NA	10.08
Social workers	3.35	NA	2.10	1.48	NA	3.42
Psychiatrists in MH Centers	NA	NA	3.57	2.81	3.50	4.19
Psychologists in MH Centers	NA	NA	3.14	2.35	2.18	2.52
Nurses in MH centers	NA	NA	0.91	1.33	1.66	2.52
Social workers in MH centers	NA	NA	1.08	0.99	1.05	1.62

MH: Mental Health / N. A.: Data not available at the time of completion. Data for Spain and Europe from WHO Atlas on Mental Health (data for Spain refers to year 1996) (WHO 2005). Autonomous Communities data refer to year 2002. In Navarre and Catalonia units refer to 1 full working staff per month. Data from Catalonia are estimates from analysis in 6 small health areas randomly selected. Data for Catalonia and Madrid have been provided by regional services with different counting method. Staff in Mental Health Centers does not count staff in centers for child and adolescent psychiatry in Catalonia and Andalucia[209, 213].

10.3.4 Social services for people with disability or dependence

With the reform of the mental health system, an increasing number of services have been shifted into social care sector[209, 213-215], but unlike health care, access to social care is discretionary and a certificate of disability provided by the relevant local authority is often needed. The formalities can be much more complicated for mental disorders. According to the process of decentralization, the ACs receive the competencies to manage social services and the AC social services are responsible for social and community care for a variety of vulnerable populations including people with intellectual disabilities, physical disabilities, mental disorders, drug addiction as well as older people. The services provided by social care departments may include different kinds of facilities (except hospital residential care and outpatient care). However, some regional services provide also hospital care for specific groups such as intellectual disabilities or drug addiction.

There is no homogeneity of the organization of social interventions between the 17 ACs. Unfortunately, there is a lack of information concerning the social care expenditure in Spain and in each autonomous region.

Key points

- **Deinstitutionalisation and "normalization" have been the main trends of the Spanish policy since the 1970s, like in other west European countries.**
- **Psychiatric care has been refocused on primary care and access to specialized care controlled through a gate-keeper system.**
- **The referral rate from primary to secondary mental health care was in 1996 about 11%.**
- **Community mental health centres are the cornerstone of specialized mental health care.**
- **Closing of psychiatric hospitals has been often compensated by new psychiatric beds in general hospitals and by a higher number of psychiatrists.**
- **However, one of the most important difficulties is the development of intermediate community services which aim at providing programs to rehabilitate and resettle patients in the community.**
- **Organization of mental health care is aiming at a strong integration between primary care and secondary care. No information was found on the realisation of these objectives.**
- **Organization and supply of care can be very different in different regions (AC's), and comparison of care supply between regions is quite complex for purely institutional reasons.**
- **Given the decentralized nature of the Spanish system, actual level of psychiatric care also depends on each region's financial capacity.**
- **Although the "psychiatric reform" has produced many achievements, a strong tendency to maintain the old mental hospital is still observed and, if the concept of deinstitutionalization is accepted by a majority, the inadequate implementation is criticized.**

10.3.5 Mapping of existing services

We use the 'Service Tree'[uuuuuuu] developed by Johnson et al. to map the mental health services[5]. We refer to chapters 2 and 6 for more information. A synthetic presentation of the ESMS tree can be found in the synthetic table below.

Table: Synthetic presentation of the ESMS tree

SECURE **(1)**			
RESIDENTIAL	Generic acute	Hospital **(2)**	
		Non-hospital **(3)**	
	Non-acute	Hospital **(4)**	Time limited **(4.1)**
			Indefinite stay **(4.2)**
		Non-hospital **(5)**	Time limited **(5.1)**
			Indefinite stay **(5.2)**
DAY & STRUCTURED ACTIVITY	Acute **(6)**		
	Non-acute **(7)**	High intensity **(7.1)**	
		Low intensity **(7.2)**	
OUT-PATIENT & COMMUNITY	Emergency care **(8)**	Mobile **(8.1)**	
		Non-mobile **(8.2)**	
	Continuing care **(9)**	Mobile **(9.1)**	
		Non-mobile **(9.2)**	
SELF-HELP & NON-PROFESSIONAL **(10)**			

[uuuuuuu] We use the results of a investigation for Italy and Spain based on the ESMS classification [213]

10.3.6 The 'Mental health care tree' in Spain

A table with an overview of available services in Spain is presented in chapter 14.1.6.

Because the great heterogeneity of the organization in mental health care between the 17 autonomous regions and the lack of information, we will present the mental health services of regions as an illustration of the existing system in Spain. We will use the results of a study concerning the provision of services for people with schizophrenia in five European regions to give a crude presentation of the mental health services organized in Santander[216, 217]. Santander is the capital of Cantabria (Autonomic Community in North Spain, population about 560 000, 1.3 % of the total population of Spain), a university town with a population of about 194 000. This study focuses on service provision for severely mentally ill persons only.

We use the results of comparison made by Salvador-Carulla et. al. between Italy and Spain using the European Service Mapping Schedule[213]. In this study, four local catchment areas are considered: Burlada (Navarra), Barcelona (Catalonia), Loja (Andalucia) and Madrid. In this study, no distinction was made as to the diagnosis or severity of involvement of service users. The synthetic table below illustrates the heterogeneity of the repartition or services in Spain.

To complete the presentation, but without obtain exhaustiveness, we use also a country report about deinstitutionalisation which concerns the residential services for people with a disability[214] to describe some services and evaluate their representativeness in Spain.

The description below mainly deals with "full mental health services" or services exclusively dealing with persons with mental health disorders. Only in the ESMS subdivision "residential non-acute non-hospital services" information has been found on "mixed services" in Spain, meant to support people with different types of disabilities or social problems.

Table 10.3: Mental health used services in 4 local areas in Spain using the ESMS – beds occupied per 100 000 inhabitants (Source: Salvador-Carulla, 2005[213])

Areas	Acute residential services		Non-acute residential services				
	Hospital	Non - Hospital	Hospital		Non-Hospital		
			Length of stay		Level of support		
			Time Limited	Indefinite Stay	24-Hour	Daily	Limited
Burlada	11.2	0	0	0	5.4	0	0
Barcelona	3.6	0	4.4	2.2	0	2.2	0
Loja	2.8	0	0	0	6.4	1.6	0
Madrid	4.3	0	0.7	6.4	3.2	0	0

10.3.6.1 Secure services (1)

One in Santander [216, 217] (out of scope of this report)

10.3.6.2 Residential mental health services

- Generic acute
  - Hospital (2)

One in Santander[216] providing 13.3 places/ 100.000 inhabitants. Salvador-Carulla, 2005[213] find between 2.8 and 11.2 acute hospital places/100.000 population in the four analysed local areas (see Table 10.3). For the whole country, there are 4569 places (about 9.9 places/100.000 population) in "**Mental health - Acute Hospital Unit** (Unidad de Hospitalzacion Breve)" (Salvador-Carulla et. al., 2007[214]). These patients are between 18 and 65 years old and receive 24 hours support and short term care.

  - Non-hospital (3)

Nor Becker nor Salvador-Carulla, 2005 find any residential services providing acute care outside hospital in the analysed local areas.

- Non-acute
  - Hospital (4)

Two services in Santander, indefinite stay[216]; together they provide 75.1 beds/100.000 population (according to the authors this high number might be caused by the presence of a university hospital in Santander). Salvador-Carulla et. al. 2005 find in 2 out of 4 areas, Madrid and Barcelona, where large psychiatric hospitals are still open, about 7 beds per 100.000 population[213]; these 2 areas have a relatively low number of generic acute hospital beds (see Table 10.3). For the whole country, there are 3 624 places (7.8/100.000 inhabitants) in "**"Psychiatric Hospitals'** (Hospital Psiquiatrico)", providing care to adults (18 to 65 years) and older adults (over 65 years) with mental disorders.

(Salvador-Carulla et. al., 2007). Another type of services are the **'Rehabilitation Hospital units/Therapeutic Communities'** (Unidades Hospitalarias de rabilitacion/Comunidad Terapeutica). They provide rehabilitation and medium-term treatment with 24 hour support for adults between 18 and 65 years old. These units are characterized by few free places and long waiting lists. The number of available places is function of the capacity (see table below, number for the whole country), the total amounts to 812 places (about 1.7 per 100.000 population).

Table 10.4: number of available places in Spain in hospital rehabilitation units ("Therapeutic communities") in function of the sheltering capacity

Sheltering capacity of hospital units	Number of available places
Between 11 and 30 people	257
Between 31 and 50 people	293
Between 51 and 100 people	60
Between 101 and 200 people	202
Total	812

Source: Salvador-Carulla et. al., 2007[214]

  - Non-hospital (5)

Two services in Santander, indefinite stay, 24-hour support[216]; together they provide 3.5 beds/100.000 population. Salvador-Carulla et. al. 2005 describes non-hospital residential (24 hour services) in 3 out of 4 areas, with 3.2 to 6.4 beds/100.000 population. Residential non-hospital services providing daily support are described in 2 areas (1.6 resp. 2.2 places/100.000 population).

Generic numbers for Spain are available as well; together about 27.8 places per 100.000 population are available in non-hospital non-acute residential services for persons with mental disorders; several types exist (Salvador-Carulla et. al., 2007[214]). First, '**Sheltered Accommodations and Supervised Residences for Mental Health** (Pisos Tutelados/Viviendas Supervisadas) for adults between 18 and 65 years old with mental health problems but who do not need 24 hour support. Inpatients receive short and long-term care, clinical and care staff overview several days per week and during some hours per day. 3 to 12 are living in this setting where 1 350 places are available throughout Spain (about 3 places per 100.000 population). The **'Mental health Homes/Residences'** (Residencias Hogar) are conceived to give long term support (24 hours) to people with mental disorders, aged between 18 and 65, and to provide respite to families. These homes can shelter between 15 and 35 persons, 740 places are available in the country (1.6 per 100.000 population). Like in France, we find **'Pensions/Hotels for mental Health'** (Pensiones/hostales para salud Mental) where the 'patient' (adult from 18 to 65 years) has an independent life but can receive some support if needed (less than 100 places throughout Spain). **Medium-stay units for Mental Health** (SM Unidades de Media Estancia) provide 24 hours support for medium-term care to adults from 18 to 65 years.

2 401 places (about 5.2 per 100.000 population) are available in al this kind of centres. For 24 hours support and long-term care, 8 143 places (about 18 per 100.000 population) are available in **'Long-stay units for Mental Health'**. The staffs of these centres are shared with 'medium-stay Units' and 'Psychiatric Hospitals'.

Mixed residential services

Only in the ESMS subdivision "residential non-acute non-hospital services" information has been found on "mixed services" in Spain, meant to support people with different types of disabilities. We find **'Centers for People with Pluridisability, Mixed disabilities, Other disabilities'** (Centro residencial para Personans con pluridiscapacidad -, Discapacidades Mixtas y Otras Discapacidades). These services are intended for adults from 18 to 60 years old with more than one disability. The typical number of places is 25; number of places is available for 3 AC only. They provide 24 hours support, long term care and family respite (the staff is shared with the services for intellectual disability).

For autonomous adults from 18 to 60 who need some support only some hours per day, houses or apartments are organized for maximum 7 persons: **'Alternative Residential Settings'** (supported living, sheltered homes, …) (Servicios Residenciales Alternativos). The number of places is available for 3 AC only. Staff is shared with the other settings of these regions.

10.3.6.3 Day and structured activity

- Acute (6)

Acute day services were identified in three of the four local geographic areas analysed by Salvador-Carulla et. al. 2005 (3.2 to 4.8 users per 100.000 population per day). This service type was not identified by Becker et al (2002).

- Non-acute (7)

Becker et al. (2002) could not identify services for day and structured activities in Santander. Salvador-Carulla et al. 2005 identified "work-related services" in one area (11.2 users per 100.000 population per day) and "other structured activity" especially in the 3 other areas (13 to 19.3 users per 100.000 population per month).

10.3.6.4 Out-patient and community mental health services

- Emergency care (8)
  - Mobile (8.1)

Nor Becker[216] nor Salvador-Carulla, 2005[213] find any 24-h mobile emergency services in the areas studied.

  - Non-mobile (8.2)

One service community emergency care non-mobile 24 hours in Santander, 42 users/100.000 population per month[216]. This service type (office hours or 24 hours) is found in all 4 areas in the study of Salvador-Carulla et al. 2005[213]: between 16 and 67.9 users per 100.000 population per month.

- Continuing care (9)
  - Mobile (9.1)

Salvador-Carulla et al. (2005) identified this service type in 2 of the 4 areas (1.6 resp. 22.4 users/100.000 population)

  - Non-mobile (9.2)

Three services of high intensity in Santander[216] with 2716 users/100.000 population per month. Salvador-Carulla et al. 2005[213] identified between 609.5 and 1675 users/100.000 population per month in the four areas.

Like in other analysed countries, psychiatrists provide continuing care for ambulant patients. The psychiatrist density in Spain is highly heterogeneous, we find only 2.6 psychiatrists for 100 000 inhabitants in Valence, 5.3 in Andalusia and 10.8 in Catalonia[218]. Globally, we find 3.6 psychiatrists, 1.9 psychologists and 4.2 psychiatric nurses for 100 000 inhabitants in Spain[213], but because the high heterogeneity, a global figure has little significance.

10.3.6.5 Self-help and non-professional mental health services

No specific information was found on this subject.

10.4 FINANCING OF THE MENTAL HEALTH CARE SECTOR

10.4.1 Global data

Like for other European countries where the health care system is organized on a national level, the financing mechanisms of the mental health system are not different from those of other health care sectors. According to a recent, but very rough estimation, the mental health care sector would account for 5 % of total health expenditures. Looking beyond funding from taxation and user charges, the role of charitable organizations including the church seems to stay important in providing residential service provision.

10.4.2 Approach per sector of activities

This paragraph aims to describe the financing following the ESMS tree if the data are available. However, given all the information described above on the Spanish health care organisation, major problems have arisen in the comparison between Autonomous Communities- AC (Spanish regions), including on funding issues, mainly for historical and institutional reasons.

Practical implementation of devolution rules

The way competences and fitting funding have been transferred since 1987 to the AC did not lead to a clear-cut power sharing between the national level and the regional entities as the mere level of autonomy depends on each AC (some of them being more autonomous than others).

More precisely, the rhythm of devolution rules has not been applied in a clear and uniform timeframe: transfer of political and funding powers was in force in 1981 for Catalonia, in 1987 for Basque Country, and in 1994 for Canary Islands. Eventually, devolution process was completed in 2002 only. Transfer of both health care and social care sectors to the ACs was obviously affected by this political process.

As a result of this specific trait of the Spanish legal system, it is virtually impossible to establish accurate comparisons on that subject between the different AC but also between Spain and other countries over the last two decades. The European Observatory on Health Care Systems described this situation in 2000 as "*specially chaotic in terms of territorial power sharing*"[209].

In most of ACs, the mere availability of data is problematic, and no further analysis can be conducted. This is particularly true for care provided under the umbrella of social services. As already mentioned before in this report - see Table XX referring to Salvador-Carulla [209]- indicators could be defined in Spain for a narrow range of items only (Psychiatric beds, psychiatrists, psychologists, and nurses) but no reliable information or data could be found for the following items: social workers, but also Psychiatrists, Psychologists, Nurses and Social workers working in regional MH Centres.

Patient management policy across the ACs

Patient management at each stage of the care pathway, and corresponding funding policy, greatly varies across ACs. As underlined in many reports (eg Vazquez-Barquero & Garcia 1999, Salvador-Carulla et al. 2002) closing of psychiatric hospitals has been applied in very different ways in the different ACs: whereas Andalucia closed all of its psychiatric hospitals by 2001, Catalonia continued to retain residential subacute and long term care within psychiatric institutions.

Therefore, the distinction between the different financial streams and financial flows does not correspond to a clear distinction between the different steps of the patient pathway.

Political aspects

From a more political point of view, mental health sector has clearly been neglected by public decision-makers on the regional level and still suffers from low financing. One key indicator is the low number of psychiatrists working in the public sector: as stated in the report of WHO of 2005 for Spain, the density of psychiatrists working in the public sector is approximately half the average in European countries.

Distinction between health care and social care sector

In addition to what has been said above, the implementation of the health reform, some services initially designed for people with mental disorders or intellectual disabilities were transferred to the social care sector. However, considering the variable level of funding for social care across the Spanish ACs, this transfer often led to a reduced access to services.

Role of the private sector in mental health care supply

Despite the virtually universal coverage of the Spanish population and the legally guaranteed access to mental health care (mental health care being part of health care without any restraint), actual implementation of this right is far from being satisfactory and universal.

Public structures are not always in the position to assume these obligations, as the mental health sector has been neglected in many ACs. Therefore, a noticeable part of mental health care is provided by private institutions (especially religious institutions and charities) for which no reliable data is available.

Main characteristics of the financing system

The main characteristics of the Spanish system can be described as below:

Mental Health Care

The Spanish system is a NHS-style system and thus largely funded by a public taxation system called "Regimen Commun". However the latter is not applied to Basque Country, Navarra, and Canary Islands in which a specific system has been set up (historical and political reasons).

Social Care

Social care as such is organised and funded by the regional level. However, no reliable data are available on that point.

Compensation funding

In order to mitigate inequality in access to health care underlined above, a specific compensation funding system has been set up.

Table 10.5: Description of the financing of the different mental health (pure and mixed) institutions and teams

Services or institutions	Financing
Full Mental Health Services	
Psychiatric beds in Psych. Hospitals	Public Taxation System (Except in Basque Country, Navarra and Canary Islands) & Compensation funding.
Psychiatric beds in General Hospitals	Public Taxation System (Except in Basque Country, Navarra and Canary Islands)
Psychiatrists	Public Taxation System (Except in Basque Country, Navarra and Canary Islands) & Compensation funding
Psychologists	Public Taxation System (Except in Basque Country, Navarra and Canary Islands) & Compensation funding
Nurses	Public Taxation System (Except in Basque Country, Navarra and Canary Islands) & Compensation funding
Psychiatrists, working in MH Centres	AC: Regional Funding (No Data)
Psychologists, working in MH Centres	AC: Regional Funding (No Data)
Nurses working in MH Centres	AC: Regional Funding (No Data)
Professionals working in Private charity institutions	No data available
Residential Mixed Services	AC: Regional Funding (No Data)
Support Mixed Teams	AC: Regional Funding (No Data)

11 DENMARK

11.1 LITERATURE SEARCH: METHODOLOGY

See general methodology. No information (references, data…) has been included after August 31, 2009. The main source of information for this chapter has been the Denmark HiT report (2007)[219].

11.2 GENERAL ORGANISATION OF HEALTH CARE

Health care services in Denmark, that has 5,4 million inhabitants (2006)[vvvvvv], are public, tax financed and organised according to a decentralized model.

- The principle of local government applied in Denmark means that, within the framework of national legislation, each local authority decides the service level in its geographical area, including criteria for the provision of services, and allocates the funds required to achieve the service level decided.
- Equity and solidarity are important underlying values in the system:

The vast majority of health care and welfare services are run directly by public authorities. People providing services are generally civil servants receiving fixed salaries. In primary care it are mainly self employed providers working under the "health care reimbursement scheme" (generalists, dentists, specialists, physiotherapists,…).

The Danish public sector, of which the health care sector is a part, went recently through major reforms which we sketch first, before describing the organisational features of the country

11.2.1 Recent important health care policy changes

Since the late 1980s the reduction of the waiting time for pre-planned treatment at a hospital has been considered the greatest political challenge. A number of initiatives have been launched to increase activity and reduce waiting time, including allocation of additional resources and initiation of experiments with new organisational structures.

Moreover, there were some rising concerns about the differential effects of decentralization in the country. The Decentralization in Denmark has lead to differences in waiting times, in the availability of medical technology and in the rates of specific diagnostic and curative activities.

We make a very brief sketch of some important measures: a recent an more detailed overview can be found in the HIT report Denmark (2007)[219]

Choice between public hospitals across regional borders was introduced in 1993.

In 1999 a three-year strategic plan for development of the hospital sector was adopted. The plan included a number of goals concerning the reduction of waiting time. In addition, new organisational structures in the hospital sector have been introduced, the so called activity-based units, in which the activities in each county are merged inter large physical or organising units across the existing hospitals in order to obtain more quality and efficiency in treatment.

In May 2002 the Danish Government launched the reform programme "Welfare and Choice". The reform programme focuses on enhancing the competition and quality of public-sector services through choice. The notion of "Extended choice of hospitals" was introduced– in order to reduce waiting times and increase choice. The extended choice of hospitals comes into effect if the public health care system is unable to provide treatment within two months. From 2007 the extended choice has effect if the public health care system is unable to provide treatment within one month.

[vvvvvv] http://www.dst.dk/HomeUK/Statistics/Key_indicators/Population/pop_quarterly.aspx

The extended choice of hospitals entitles patients – free of charge - to treatment at a private hospital in Denmark or abroad that has entered an agreement with the Danish regional authorities. The treatment is at the expense of the region where the patient is residing.

One of the goals of the 2007 reform is to ensure equal standards of care throughout the country by increasing the power of the state bodies in planning and quality management. A major objective of the 2007 reform is to provide a basis for making quality and performance comparisons between the regions. The policy makers aim that differences socio-economic characteristics and general state of the health of the region will be eliminated as causes for differences in the health care performance of each region. The 2007 reform also implies a more important role for the central level. With the reform, the influence of the National Board of Health on hospital planning was strengthened with the purpose of ensuring more equal treatment across the country. Implementation of policies and provision of services continues to take place at the regional and local levels.

11.2.2 The policy-levels in health care

a. The central State's role is almost exclusively regulatory, supervisory and fiscal. At state level the Ministry of Health has a governing role over municipal organization and management, as well as the supervision and partial financing of the municipalities and regions. The National Board of Health, since the recent reforms connected to the Ministry of Health, is responsible for supervising health personnel and institutions, and for advising different ministries, regions and municipalities on health issues.

b. Five regions own and run hospitals, and partly or fully finance private practitioners such as general practitioners (GPs), specialists, physiotherapists. They also provide reimbursement for pharmaceutical care. Reimbursements for private practitioners and salaries for employed health professionals are agreed through negotiations between the Danish Regions and the different professional organizations.

c. At the local level, the municipalities are responsible for providing services such as nursing homes, home nurses, health visitors, municipal dentists, prevention and health promotion, and institutions for people with special needs (i.e. people with disabilities, treatment for drug- and alcohol-related problems and school health services). These activities are financed by taxes, with funds distributed through global budgets, and carried out by salaried health professionals.

The Danish Ministry of Health and Prevention was founded after the 2007 elections. It is a split off from the previously combined Ministry of the Interior and Health[wwwwwww].

Responsibilities include Prevention and health promotion, coordination and research streamlining of the Danish Health service (sundhedsvæsenet), Danish Hospital service (sygehusvæsenet), the Danish Public Social Security (den offentlige sygesikring) as well as the approval of pharmaceuticals and the pharmacy sector.

Until January 2007, the prime responsibility for health care lied with the Counties. 14 Counties in Denmark and Copenhagen. were responsible for organising hospitals and primary care adapted to the local needs. After the 2007 reforms this responsibility is now in hands of five regions. The new regions have not – as was the case of the counties –the power to impose taxes. The funding of the regions will be based on demographic characteristics and the amount of services they provide. Both the State and the Municipalities provide tax based financing for the new regions.

The Municipalities provided Primary and Social Health Care. There were 275 municipal councils who are responsible for providing home nursing, school health care and child dental services as well as social services through nursing homes, home helpers and social psychiatric services.

[wwwwwww] http://www.sum.dk/

Most decisions regarding the form and content of health care activity have been made at county and municipal level. There are channels for co-ordination and negotiation between the state and the counties and municipalities and between the counties and the municipalities. The political focus on controlling health care costs has encouraged a greater degree of formal co-operation

The 2007 reform outlines a new public sector in which local authorities, regions and the state maintain similar but adapted separate task identities. The state sets up the overall framework. Local authorities will handle tasks directly targeted at citizen, thus becoming the main gateway to the public sector for citizens and companies.

Five new regions were defined for organising for the health sector and regional development tasks and will be charged with performing certain operational activities on behalf of the local authorities.

The 99 new local authorities will assume wider responsibility in a range of areas, including the social and health areas. The will keep their old responsibility in organising long term care, but get an enhanced role in the health sector, notably in the field of prevention. The will be held responsible for guaranteeing greater coherence in patient treatment with other related treatments e.g. in the social field and will become responsible for all rehabilitation not performed at the hospitals. Furthermore, the local authorities will also be responsible for specialized dental care and treatment of alcohol and drug abuse.

11.2.3 Organisation of the Danish health care sector

The Danish public health sector consists of the primary and the secondary health sectors. Hospital treatment of non-emergency cases requires referral from a general practitioner, who thus assumes a gatekeeper function.

11.2.3.1 The primary line

The primary sector consists of general practitioners, specialist practitioners, visiting health nurses, dental care, and preventive health schemes for children and young people etc. The National Health Insurance and the local authorities finance the sector. Local authorities are responsible for the home nursing offered to citizens free of charge if referred by a practitioner. The home nursing include nursing and caring for the patient and general health guidance according to the need of the patient. Moreover, the local authorities are responsible for home visits by health nurses who guide future and new parents, for prevention actions among children and young people under 18 as well as for their dental care. Special groups of people with disabilities are also a local authority responsibility. Local authorities are responsible to provide assistance for the necessary personal care and practical tasks at home that individuals are unable to perform.

11.2.3.2 The secondary line

The secondary health sector consists of the hospitals, including psychiatric treatment within hospitals. The counties and the Copenhagen Hospital Corporation operate the sector. As mentioned, hospital treatment is free, but non-emergency treatment requires referral from a general practitioner or specialist practitioner.

Denmark introduced free choice of hospital across county borders for all citizens in 1993 to meet a desire of greater self-determination from the patients. At the same time it was expected that it would even out the differences in waiting times across counties, without much success. As of 1 July 2002, free hospital choice was enhanced so that patients waiting longer than two months for public hospitals are entitled to treatment at a private hospital or a hospital outside Denmark which the counties have an agreement with. As of 2007 citizens are granted the right of enhanced free choice if the public hospital is unable to offer treatment within one month.

11.2.4 Funding in general terms

The main financing of the health care sector comes from municipal and central state taxation. A major administrative reform in 2007 gave the central government responsibility for financing health care. Health care is now mainly financed through a centrally-collected tax set at 8% of taxable income and earmarked for health. The new proportionate earmarked tax replaces a mixture of progressive central income taxes and proportionate regional income and property taxes. The central government allocates this revenue to five regions (80%) and 98 municipalities (20%) using a risk-adjusted capitation formula and some activity-based payment. Public expenditure accounted for around 82% of total health expenditure in 2005 (World Health Organization 2007).

Around 30% of the population purchase complementary private health insurance covering statutory cost sharing from the not-for-profit organization 'Danmark.' Supplemental private health insurance provided by for-profit companies offers access to care in private hospitals in Denmark and abroad. It covers around 5% of the population and is mainly purchased by employers as a fringe benefit for employees. In 2005, private health insurance accounted for 1.6% of total health expenditure.

The central State subsidizes the regions and municipalities Regions and municipalities are responsible for providing the majority of health services in Denmark, but they must stay within the health care expenditure limits that were agreed on during annual negotiations. This national budget negotiation takes place once a year between the Ministry of Health, the Ministry of Finance and the regional and municipal councils, which are represented by the Danish Regions and the National Association of Local Authorities.

In 2000 activity based funding has been introduced: the introduction of activity based funding went hand in hand with policy measure to reduce waiting lists: one of the measures take was offering patient choice to get treatment over county borders (outside the county of residence). In 2002 an additional measure was taken to give patients the freedom of choice if the waiting list exceeded 2 months. Moreover it included the to go abroad or to receive care in private hospitals: the costs for this are on charge of the county of residence of the patient: The county reimburses 100% of costs for hospital treatment outside the county of residence based on DRG defined prices. For treatment and care abroad or in private hospitals the prices are negotiated between the counties and private hospitals. The public authorities have entered agreements with 157 private hospitals in Denmark and abroad.

11.3 MENTAL HEALTH SERVICES ORGANISATION

Most of the information of this chapter comes from the HIT report (2007)[219].

11.3.1 Mental health care reforms

Since the 1970's mental health care policy is putting major emphasis on reintegration into society and on developing and elaborating adapted health and welfare services for people with mental illness in local community. Psychiatry has developed from long-term admission to psychiatric departments to shorter admissions and more outpatient and district psychiatric treatments combined with social psychiatric day services. The aim of this change was to integrate the mentally ill better into society.

The implementation of this organizational change was followed by coordination and service coherency problems. The division of responsibilities between counties and municipalities lead to organizational fragmentation. The counties developed a number of subsequent organizational changes in order to secure coordination and coherence of services within and between the clinical psychiatry and social psychiatry.

The public services for patients with mental disorders are provided in cross-sectoral collaboration between the health care and the social sector. The regions are responsible for health care services, and the municipalities are responsible for the social psychiatric services. The main responsibility of the regions is a specialised effort towards the long-term mentally ill. The municipalities take care of all other psychiatric tasks.

Some of the social psychiatric services, which are provided by the regions and municipalities, however, are partly overlapping complicating an effective coherence between decision competence and financing responsibility.

The process of decentralizing psychiatric treatment is still continuing today, with the aim of delivering flexible and well-coordinated services. The latest development within the psychiatric field has been the establishment of new organizational forms with outgoing and interdisciplinary teams for treatment of the mentally ill in their homes or within their living arrangements. These new organizational forms target towards the most challenging group of mentally ill patients in order to create a uniform and coherent service. This service can include treatment, various social psychiatric services, educational services, and so on (HIT report).

As an example the drug addiction approach can be mentioned: Currently, Out-patient treatment is the most common type of treatment used, usually in the form of methadone prescription with supportive psycho-social services, including support in the home, stays in sheltered facilities, activation and rehabilitation. Formerly, services for drug addicts were primarily aimed at the drug misuse itself and at making the addicts drug-free. More recently the focus has been put on the development of differentiated approaches with objectives of in certain cases, harm reduction, as the elimination of the misuse is accepted as unrealistic in the short term, and health, social and other services are provided instead.

In 1977, responsibility for psychiatric hospitals was transferred from the State to the counties. The 1970 reforms were as part of an effort to develop closer coordination between somatic and psychiatric care, and, more generally, to establish smaller units of psychiatric that would be closer to the population. The reforms led to a major decrease in hospital beds, going hand in hand with increased local and district psychiatric outpatient treatment.

The organizational reforms resulted in many mentally ill people living in their homes, but as was experienced in different countries, the integration into wider society has not always been successful, especially in the big cities, where people have ended up homeless or living in shelters.

Full implementation of the organizational change in psychiatric care did not take place until the 1990s. Specific problems were experienced with coordination and service coherence. As services were provided on the boundaries of counties and municipalities many problems emerged due to fragmentation. The counties made a number of subsequent organizational changes in order to secure coordination and coherence of services within and between clinical psychiatry and social psychiatry care. This movement was continued in the recent reform towards more regional approaches. The regions remain responsible for health care services in particular for the long-term mentally ill, and the municipalities are responsible for the social psychiatric services. But there is partial overlap of some of the social psychiatric services that are provided by the regions and municipalities, which leads to remaining problems.

As to the coordination between primary and secondary care, the GP has a gate-keeper role and when a patient is referred to a (psychiatric) specialist by his GP, the specialist service is fully reimbursed.

For the coming years, some further rather fundamental reforms in mental health care organisation are expected. The debate is ongoing on the future distribution of responsibilities and the organizational structure of mental health services, also related to the major reforms of early 2007.

In 2003, there were 1179 FTE psychiatrists active in Denmark (21.8/100.000 population). In 2000, there were 108 FTE *independently* practizising psychiatrists, only a minority (HiT report 2007)[219].

11.3.2 Mental health care organisation: the 'Mental health care tree' in Denmark

For other countries, the 'Service Tree' developed by Johnson et al. was used to map the mental health services[5]. We refer to chapters 2 and 6 for more information. In Denmark, not enough detailed information could be found to perform this exercise, mainly because a lot of local documents were only available in Danish. Below, some general information on mental health care organization in Denmark is discussed.

A table with an overview of available services in the different countries discussed in this report is presented in chapter 14.1.6.

11.3.2.1 Residential services

Hospital psychiatry

The hospitals are charged with examining, treating and caring for citizens referred from the primary sector. This applies to both the somatic and the psychiatric areas.

The number of beds in hospital and district psychiatry services was 3799 in 2002 (HIT report), or 70,3 beds per 100.000 population; according to Priebe S et al (2008)[220] it was 75,8/100.000 population in 2006. This is approximately one fifth of the beds available in Danish somatic hospitals. The following tables present some information on residential psychiatric treatment for the 6 regions in 2006.

The number of beds in psychiatry (adults)

	2006
Region Hovedstaden	1.461
Region Sjælland	402
Region Syddanmark	534
Region Midtjylland	492
Region Nordjylland	269
I alt	**3.158**

The general decline over the lasts decennia in the number of beds in psychiatric hospitals has been associated with a large increase in the number of outpatient visits. Many diagnostic and therapeutic procedures now take place without inpatient admission or before and after inpatient stay. But the increased risk of suicide, compulsory hospitalization and abuse among psychotic patients in Denmark can, to a certain extent, be explained by the rate of deinstitutionalization and patient dropouts in community psychiatry, despite the fact that one of the basic principles in outpatient treatment is continuity of care (Aagaard 2004)[221].

Psychiatric Nursing homes

Ordinary nursing homes are run by the municipalities. There are many private (independent) nursing homes, which receive residents according to a contract with the municipality where they are located.

Specialized nursing homes, in particular psychiatric nursing homes are run by the regions.

Priebe S et al (2008)[220] estimates that Denmark in 2006 had 86,9 places/100.000 population for non-hospital residential care and supported housing, including social psychiatry places (see further) and initiatives of sheltered living.

11.3.2.2 Outpatient & community services

District psychiatry (community mental health care)

In addition to the in-patient beds there are also day hospital and community services. Almost all of Denmark is served by "district psychiatric services" [xxxxxxx], with approximately 120 units across the country. The service is provided on a district basis, a sub-level of the county (but larger that a municipality). A district psychiatric unit is established locally, providing outpatient care and interdisciplinary psychiatric treatment.

Most treatment is conducted at the mentally ill patient's residence. The treatment is provided by district psychiatric teams, which comprise interdisciplinary doctors, nurses, social workers, occupational therapists, psychologists, physiotherapists, and so on.

In some regions, these teams are located locally in district psychiatric centres, which are sometimes connected with a day care centre. In 2002 the counties had 2061 day centre accommodation places (HiT report, 38.1 places/100.000 population). Other regions have placed the teams in hospitals' psychiatric departments.

Some regions district psychiatric services strictly provide services only for people with long-term and socially disabling diseases, while others also include services for people with short-term mental illness.

A referral is needed for a mentally ill person to seek treatment from district psychiatry care providers. The referral can be obtained from a GP, the hospital or, in some cases, the caseworker.

District psychiatry has been criticized for providing insufficient treatment, which is primarily explained by a lack of economic resources and a reduction in the number of beds without simultaneously increasing outpatient care resources.

The planned extension of residential institutions outside of hospitals has not yet been executed, despite the fact that a third of the available psychiatric beds have been removed from service.

Social psychiatry

Social psychiatry [yyyyyyy] developed from social work and not - as in most other countries - from hospital psychiatry. Social psychiatry is recognised as specialist sector, providing in the broadest possible definition, social services for people with psychiatric disabilities. It operates under Danish social law to ensure that fundamental citizen rights and entitlements are available for people with psychiatric disabilities. In other words, it comes under the Ministry of Social Affairs, while Hospital psychiatry comes under the Ministry of Health. The municipalities have the primary responsibility for social psychiatry, and the regional authorities are responsible for those services requiring special competencies.

Social psychiatry is a complement to clinical treatment psychiatry services and the broad range of generalist community social services working to ensure that the needs and right of people with psychiatric disabilities are met. The activities provided by these services can be compared to the "psychosocial rehabilitation sector", and the "non clinical community mental health sector". The concept of social psychiatry could be translated into "social work aimed at mentally ill people". The basic concept calls for support to the individual mentally ill person - who is no longer a patient of a psychiatric hospital - in managing everyday life. It is conceptualised as support for personal and social empowerment.

[xxxxxxx] http://www.distriktspsykiatri.dk/
[yyyyyyy] http://www.socialpsykiatri.dk/

Social psychiatry includes a range of different residential facilities, shelters, community centres and support and contact person schemes complementary to the conventional services mentally ill people, e.g. case administration and home care. The concept of social psychiatry covers all these service offers, thus making the mentally ill person, the professionals, the volunteers and the Act on Social Services key players in social-psychiatric work. Hospital psychiatry and social psychiatry supplement each other, but are rooted in different traditions. In actual fact, many counties have merged the administration of the entire psychiatry area into one unit.

Crisis home programmes

A Crisis Home programme is inspired by the principles of the Assertive Community Treatment (ACT), in which adult psychiatric patients, as an alternative to admission to hospital, spend some time in a private family. The possibility to stay in a Crisis Home has the potential to ameliorate the condition and reduce the risk of readmission of patients suffering from severe mental illness (Aagaard 2008)[221, 222]

All the services involve the option of 24-hour care, and most offer places in day-care or support centres.

11.4 FINANCING OF THE HEALTH CARE SECTOR

11.4.1 Global data

In 2005, Danish health care expenditures as share of GDP constituted 9.4%. Health care activities are now financed largely through a national earmarked health tax (8% of income), redistributed in terms of block grants to regions and municipalities. The earmarking of health taxes is a new feature of the 2007 reforms.

There are two sources of financing for the region's health expenses: the state and the local authorities[zzzzzzz]. The regions, as opposed to the previously existing counties, cannot impose taxes. A major administrative reform in 2007 gave the central government responsibility for financing health care. Regions are partly financed by the municipalities and partly by the state. A novelty is that the municipalities are co-financing health care.

- Block subsidy from the state: 80%
- Activity based funding – 5%

The remaining funding comes from a combination of per capita and activity based payment contributions by municipalities.

The size of these block grants is calculated using a formula where expected need for health care in the population is a central component. This level of need is assessed by combining the distribution of age and socioeconomic status in the region. The purpose of activity-based payments is to encourage the regions to increase activity levels within hospitals.

zzzzzzz www.sum.dk

11.4.2 Approach per sector of activities

Activity based financing of hospitals has been introduced in Denmark.

Psychiatric treatment at the hospitals is financed via subsidies and contributions from the state and the local authorities. Historically, hospitals were reimbursed through fixed prospective global budgets negotiated between the counties and hospitals, where the contracts stipulated production, quality, and research and development objectives for the fiscal year. Since 2000 there is a two-part hospital financing scheme. The first part consists of the negotiated base budget (approximately 80% of the hospital's total financing), and the second part entails activity-based financing based on Diagnosis Related Groups (DRGs).

The government manages public health costs through negotiations between the state and the counties. Most counties manage hospital costs through target-oriented and framework management combined with contract management. Annual negotiations between the central government and the regions and municipalities result in agreement on the economic framework for the health sector, including levels of taxation and expenditure. The negotiations contribute to control of public spending on health by instituting a national budget cap for the health sector. They also form the basis for resource allocation from the central government. At the regional and municipal level, various management tools are used to control expenditure, in particular contracts and agreements between hospitals and the regions, and ongoing monitoring of expenditure development.

11.4.3 Financing of the mental health care sector

The financing of psychiatric hospital care and district psychiatry belongs to the responsibility of the regional councils, the social psychiatry however is financed by the municipal councils (HiT report)[219]. The operation of social psychiatry institutions and services is performed in accordance with annual operational agreements with the local authorities, which pay all the associated costs.

12 ENGLAND

12.1 LITERATURE SEARCH: METHODOLOGY

See general methodology. No information (references, data…) has been included after August 31, 2009.

12.2 GENERAL ORGANISATION OF HEALTH CARE IN ENGLAND

The National Health Service (NHS) provides the majority of healthcare in England. The National Health Service (NHS) was set up in 1948 to provide free healthcare for all the residents of the UK.

The initiatives of the late 1990 NHS reforms are characterised by[aaaaaaaa]:

- increasing patients' choice in using health care services;
- engaging a wider range of providers to provide health care services;
- developing a focus on quality standards and monitoring compliance with the required standards among both the NHS and the non-governmental sectors; and
- introducing a new payment mechanism that rewards efficient providers

In the last decade, the structure of the NHS has undergone considerable change. The private sector now has a increased role in supplying and funding some buildings and services within the NHS. The major difference between the private healthcare sector and NHS is that the first provides all the services that are also provided by the NHS, but does not have "public" responsibility for the health of the wider local community, does not have the same structures of accountability and does not have to follow national treatment guidelines and health plans.

After the reforms. NHS Foundation Trusts have been created to devolve decision-making from central Government to local organisations and communities. The government hopes that by 2008 all NHS trusts will be able to become foundation trusts. However, foundation trusts are a highly contested issue. High-achieving NHS trusts can opt out of NHS control and receive foundation status, which means that their hospitals can effectively run themselves. They remain part of the NHS and people continue to receive free healthcare, but foundation trusts have more freedom and financial flexibility and less central control and monitoring. They are owned by their community, local residents, employees and patients and have the power to manage their own budgets and shape their healthcare provision according to local needs and priorities

There are several types of NHS trusts:

- Primary Care Trusts (PCTs), which administer primary care and public health. PCTs are at the centre of the NHS
- NHS acute Trusts. These look after hospitals that provide short-term care, such as Accidents and Emergencies, maternity, surgery, x-ray
- NHS Ambulance Services Trusts: over 30 ambulance are responsible for providing transport to get patients to hospital for treatment
- NHS Care Trusts: these trusts work in both health and social care and they can carry out a variety of services, such as mental health services. They are generally set up when the NHS and a local authority decide to work closely together
- NHS Mental Health Services Trusts: a number of specialist mental health trusts provide care, such as psychological therapy and specialist medical and training services for people with severe mental health problems

aaaaaaaa http://www.legco.gov.hk/yr06-07/english/sec/library/0607rp02-e.pdf

The government department responsible for the NHS is the *Department of Health*, headed by a Secretary of State for Health (Health Secretary)

NHS Strategic Health Authorities (SHA) are part of the structure of the NHS. In 2002, the existing *NHS Health Authorities* were renamed and merged to form *Strategic Health Authorities*. England is split into 10 strategic health authorities, each serving 2.5 million to 7.4 million people. Strategic health authorities do not deliver health care services. Their main responsibility is to monitor the public health care services within their respective regions. They have to ensure that primary care trusts follow policy directions set by the government and monitor the performance of primary care trusts. In addition, strategic health authorities are responsible for developing strategic directions to improve the public health care services in their respective regions

Each SHA area contains various NHS trusts which take responsibility for running or commissioning local NHS services.

Health services are divided into "primary" and "secondary" and are provided by local NHS organisations called "trusts" and these are directly accountable to the strategic health authorities.

- Primary care[bbbbbbbb] is delivered by about 300 "primary care trusts" covers everyday health services such as GPs' surgeries, dentists, NHS-walk in centres, opticians. They decide what health services their area needs and have responsibility for making sure these are delivered efficiently. Primary care trusts are a crucial part of the NHS and they receive about 75% to 80% of the NHS budget. They also control funding for hospitals, which are managed by "acute trusts". Primary care trusts can also outsource work to private companies. The primary care trusts assume both a funder's role and a provider's role. For those primary care trusts which own health care facilities, they provide health care services directly. The remaining primary care trusts commission services from other health care providers.
- Secondary care cccccccc refers to specialised services such as hospitals, ambulances and mental health provision and these are delivered by a range of other NHS trusts.

Social care is distinguished from health care and organised and funded differently. But for long term conditions (mental health care), late 1990's reforms, policy measures aimed at more coordination between NHS and social care, by allowing the creation of "care trusts" and budget sharing mechanisms.

The Department of Health role concentrates mainly on the strategic development of health care and overseeing performance. SHA's monitor the roles of the buyers and providers of healthcare for their region.

12.3 GENERAL FINANCING PRINCIPLES OF HEALTH CARE

The UK health care is mainly financed by taxation, plus small co-payments and social insurance contributions.

The bulk of health care expenditure is public. Only a small proportion is private expenditure

Through the budgetary process, the resources dedicated to health are allocated to various health care providers, in particular the primary care trusts which control around 80% of the NHS budget. The allocation of health care resources to the primary care trusts is based on a weighted capitation formula. The aim of the formula is "to secure equal opportunity of access to health care for people at equal risk" (Department of Health).

The primary care trusts use the allocated monies for the provision of health care services in their respective districts.

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bbbbbbbb http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/index.htm

cccccccc http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Secondarycare/index.htm

Before the recent reforms, The Department of Health (DoH) allocated resources between regions. The regional health authorities distributed funds to individual hospitals and remunerated general practitioners (GPs) GPs were not formally employed by the NHS

Since the late 1990s reforms the Department of Health determines allocation of funding between PCTs. It is based on a contracting model between the commissioners and providers of care, based on standard scales of charges. The intention is that patients are given a choice of provider and "money will follow the patient"

12.4 ORGANISATION OF MENTAL HEALTH CARE:

12.4.1 Policy reforms in the organisation of mental health care

As is the case for several European countries, the reforms in the mental health care sector for SMI-patients are characterised more by a gradual evolution, than an introduction of single stage "master policy reform" for the sector. The reforms in the sector are clearly inspired by the deinstitutionalization movement in the western world.

The substantial variation between areas in the services available, and in a context of major policy changes in health care in general at the end of the 20th century, the UK policymakers changed some of the principles of mental health care organisation.

The development of genuine community-based services was relatively slow until the early 1990s. The question has been raised as to whether the shift from hospital-based care to community-based care has gone *too* far, or whether the well-publicised problems of care in the community, related to murder cases committed by psychiatric patients, are due to in-patient services being closed before adequate replacements were developed.

A series of policy initiatives in the 1990s have attempted to consolidate community based services around an appropriate balance between care and control, support and public safety.

In 1995, concern about discharged patients "slipping through the net" of aftercare services led to the *Mental Health (Patients in the Community) Act 1995*. for "aftercare under supervision": patients could be discharged after detention in hospital but still be required to live in a certain place, allow access to certain professionals, and attend for medical treatment at specified times and places. The Act stopped short of requiring patients to accept treatment, but the hope was that if patients remained in touch with the system they would be more likely to continue taking treatment.

The white paper "Modernising mental health services: safe, sound and supportive (1998)" set out to identify and fill the gaps in service provision.

The National Service Framework for Mental Health, published in 1999, sets out the policy context, values, standards and implementation programme for mental health services, articulated through a broad set of standards that must be achieved in local services.

The NHS Plan (2000) extended the agenda described by the national service framework by detailing new services, including assertive outreach, crisis resolution (sometimes called home treatment) and early intervention in psychosis services.

The plan introduced graduate primary care mental health workers, gateway workers and carer support workers and endorsed structural changes such as the creation of care trusts. It also considered the mental health workforce requirements and issues relating to recruitment and retention, leadership and training.

The National Service Framework for Older People (2001) includes a specific standard around mental health in older people with the aim that older people with mental health problems have access to integrated mental health services. However, the focus of policy, local priorities and the national performance indicators remain centred around adult mental health services.

This National Service Framework addresses the mental health needs of working age adults up to 65. It sets out national standards; national service models; local action and national underpinning programmes for implementation; and a series of national milestones to assure progress, with performance indicators to support effective performance management. An organisational framework for providing integrated services and for commissioning services across the spectrum is also included.

We quote from the executive summary of the service framework:

"The programme of national service frameworks is part of the Government's agenda to drive up quality and reduce unacceptable variations in health and social services. In the NHS, standards will be:

- *set by the National Institute for Clinical Excellence and National Service Frameworks
- *delivered by clinical governance, underpinned by professional self-regulation and lifelong learning
- *monitored by the Commission for Health Improvement, the new National Performance Assessment Framework, and the National Survey of Patients.

One particular standard in the report addresses the issue of delivering effective services for people with SMI. It describes the underlying principles for offering services. The framework pays a lot of attention to the community care models and the role of local health and social care communities. Moreover the framework imposes a performance assessment at a national level.

Alongside the development of new service models, the Government has developed proposals to reform the Mental Health Act (1983) to bring it in line with the way in which contemporary mental health services are provided.

In 2007 a new Mental Health Bill passed, amending the1983 Mental Health Act.[ddddddd] The mental Health Bill provides the legislative basis of mental health care policies. The policies are part of the current Government's health policy agenda, mainly due to the increasing recognition that mental health care services are very poorly funded compared to somatic health care services[eeeeeeee]. The Government also plans to extend patient choice in mental health care, by giving patients more say in how, when, where and what treatments they receive, so that they can organise their care to fit better with their lifestyles[fffffff]. The Bill makes seven main amendments to the Mental Health Act 1983. We quote the most relevant in relationship to the purpose of this research:

- Introducing supervised community treatment (SCT) for suitable patients following an initial period of detention and treatment in hospital to ensure that patients comply with treatment after discharged from hospital and to prevent relapse. It should include easier recall to hospital if a patient does need treatment. SCT aims at protecting patients with serious mental health problems and others from harm.
- introducing a simplified single definition of mental disorder in order to avoid that patients are denied care or treatment because they do not fall within one of the existing legal categories of mental disorder.
- Introducing a new criterion for compulsion, that appropriate treatment must be available. Patients can only be detained if medical treatment, which is appropriate to the patient's mental disorder and all other circumstances of their case, is available. This "appropriate treatment test" will replace the so-called treatability test.

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ddddddd http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=243156&NewsAreaID=2&NavigatedFromDepartment=False

eeeeeeee Adam Oliver. "Developments in mental health policy". /Health Policy Monitor/, April 2007. Available at http://www.hpm.org/survey/uk/a9/4

fffffff http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=239917&NewsAreaID=2&NavigatedFromDepartment=False and www.mhchoice.org.uk

- Broadening the range of professionals that can take on key roles in the Mental Health Act. Professionals with the right skills, expertise and training will be allowed to carry out important functions in mental health care not currently open to them.
- Ending finite restriction orders. This will mean restrictions will remain in force for as long as the offender's mental disorder poses a risk of harm to others.
- The Bill is also being used to amend the Mental Capacity Act 2005 (the Bournewood safeguards) providing safeguards for people who lack capacity to make decisions for themselves, who are deprived of their liberty in care homes or hospital and are not eligible to receive mental health legislation safeguards. These safeguards will prevent arbitrary decisions to deprive a person of liberty and give rights of appeal.

12.4.2 National institute for mental health[gggggggg]

In mid-2002, the National Institute for Mental Health (NIMHE) – a new part of the Department of Health – was launched[hhhhhhhh]. The Institute brings together the research, development and dissemination functions of mental health services. The creation of NIMHE fits in the reform of mental health services. It builds on the strategy set out in Modernising Mental Health Services (1998) which initiated a radical programme of modernisation to improve access to effective treatment, care and support, reduce unfair variation, raise standards, and provide quicker and more convenient services. The institute has to ensure the development of evidence based mental health services and take fully into account the wider issues of social inclusion and the development of the communities in which people live and work. It has to support the the implementation of other NSFs and national strategies. The institute covers the full range of mental health services in primary, specialist and tertiary care organisations.

NIMHE is structured around four components: a small administrative centre, regionally based Mental Health Development Centres, a National Mental Health Research Network, a series of time-limited programmes, for example to develop mental health in primary care, but also programmes on integrated care (Integrated Service Improvement programme www.isip.nhs.uk)

12.4.3 A review of community mental health services

Every area in England has a local implementation team (known as LITs) to organise the health services in their area. They are made up of all the main organisations involved in local mental health services including: primary care trusts; local councils that have responsibility for social services; and NHS trusts.

An "improvement review" of the health care services has been commissioned in 2005/6[iiiiiiii] the Healthcare Commission and the Commission for Social Care Inspection (CSCI) decided to carry out this joint review. The commission focussed on the quality of specialist adult mental health services provided in local communities in England in 2005/2006. and whether the services that are being provided are actually helping people to recover and to become part of their local community again.

The findings of the review[jjjjjjjj] show that, since the introduction of the National Service Framework for mental health, there has been a steady improvement in the range and quality of services. Local Implementation Teams (LITs) appear to be an effective vehicle for commissioning and delivering new models of community mental health.

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gggggggg http://www.nimhe.csip.org.uk/

hhhhhhhh http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008581

iiiiiiii http://www.healthcarecommission.org.uk/healthcareproviders/serviceproviderinformation/reviewsandstudies/servicereviews/improvementre/adultcommunitymentalhealthservices.cfm

jjjjjjjj http://www.healthcarecommission.org.uk/newsandevents/pressreleases.cfm?cit_id=5591&FAArea1=customWidgets.content_view_1&usecache=false

Each of England's 174 LITs was assessed on three criteria: the involvement of the people who use services; access to appropriate care and treatment (such as talking therapies); and recovery and social inclusion. Fifty-four per cent of LITs were found to be performing consistently well across all three areas. The remaining 46% scored 'fair' or 'weak'. The report found room for improvement in all LITs as well as noticeable variations in performance between the regions.

The review found 'considerable underperformance' in a number of areas relating to choice, some of which can compromise the safety of those using the services.

Access to services remains limited. For instance, the majority of LITs reported that people could see a mental health professional (1) 24 hours a day, 365 days a year. However, less than half said they had the relevant phone number to call. There was also patchy access to effective psychological treatments. Cognitive behavioural therapy (CBT) and family intervention can be vital to people's recovery and their social inclusion. The review included a survey of 7,446 people with schizophrenia or suspected schizophrenia. Under the National Institute for Health and Clinical Excellence (NICE) guidelines, each and every one should be offered CBT. Worryingly, just 46% were.

People with mental health problems continue to face exclusion from areas of life that many take for granted. Employment rate among sufferers is the lowest out of all the main groups of people with a disability. But nationally, the review found only 50% of those who needed help with finding employment received it.

There were similarly poor performances for physical health checks. People who use mental health services are often vulnerable to poor health through issues of self-neglect, lifestyle, diet and the side-effects of medication. Though a high number of LIT areas were offering physical health checks, very few were ensuring that these were being carried out. A field study, completed as part of the review, found that some people even felt their health needs 'are not taken seriously'.

The commissions noted in the report that direct payments to patients are an important way of people taking control of their own care provision by directly purchasing the services they require. Local councils are responsible for offering and providing direct payments following an assessment of needs. The review found that the take-up of direct payments remains low, and within this, take-up by people who use mental health services lags behind other groups.

12.5 DESCRIPTIVE CHARACTERISTICS OF MENTAL HEALTH SERVICES

12.5.1 Preliminary comments

We use the 'Service Tree' developed by Johnson et al. to map the mental health services. We refer to chapters 2 and 6 for more information. A synthetic presentation of the ESMS tree can be found in the synthetic table below.

A table with an overview of available services in the different countries discussed in this report is presented in chapter 14.1.6.

Table: Synthetic presentation of the ESMS tree

SECURE **(1)**			
RESIDENTIAL	Generic acute	Hospital **(2)**	
		Non-hospital **(3)**	
	Non-acute	Hospital **(4)**	Time limited **(4.1)**
			Indefinite stay **(4.2)**
		Non-hospital **(5)**	Time limited **(5.1)**
			Indefinite stay **(5.2)**
DAY & STRUCTURED ACTIVITY	Acute **(6)**		
	Non-acute **(7)**	High intensity **(7.1)**	
		Low intensity **(7.2)**	
OUT-PATIENT & COMMUNITY	Emergency care **(8)**	Mobile **(8.1)**	
		Non-mobile **(8.2)**	
	Continuing care **(9)**	Mobile **(9.1)**	
		Non-mobile **(9.2)**	
SELF-HELP & NON-PROFESSIONAL **(10)**			

For the mental health service mapping exercise kkkkkkkkk , clearly operationalised documents have been developed for identifying the different types of mental health services [lllllllll] Online reports of services can be consulted from http://www.amhmapping.org.uk/reports/live.php This website describes the regional distribution of different types of facilities and is updated regularly. However, the department of health presents different estimates.

Glover (2007) (http://www.amhmapping.org.uk/reports/live.php) has made an estimation of existing services confronting the service mapping estimates and the department of health estimates (see also Glover 2007)[223].

Mental health care provided outside the NHS falls into three broad categories.

- A small amount of general outpatient and inpatient mental health care is provided privately and paid either directly or through private health insurance.
- A substantial proportion of the psychodynamic psychotherapy falls outside the NHS.
- A significant amount of inpatient care is provided by independent sector hospitals but funded by the NHS.

Social care is distinguished from health care. It is organized and funded in a different way, although initiatieve are being set up to integrate the provision of health and social services for persons with mental health problems..

kkkkkkkk http://www.mind.org.uk/NR/exeres/1DACC349-5B6B-427C-AD09-B754A3E02516.htm?NRMODE=Published&wbc_purpose=Basic&WBCMODE=PresentationUnpublished

lllllllll http://www.mhcombinedmap.org/Support.aspx

During the late 1980s and early 1990s there was a rapid reduction in health service provision for both working age and older adults needing long-stay care. Government funding incentives designed to encourage privatisation of this type of care initiated this. Initially these provided central government funding for people in independent sector accommodation. In the early 1990s, in an attempt to contain costs, funding responsibility was moved back to local government. At the same time a government initiative was launched to re-establish long-term NHS accommodation for the small number of long-term chronically ill adults of working age in need of continuing nursing care. However, by this time large numbers of patients had been transferred into independent sector care homes, often with little or no continuing supervision from the psychiatric teams of their district of origin.

12.5.2 Mental health care trusts and primary care trusts

The organisational provision of mental health services has changed rapidly with the creation in England of specialist mental health trusts and the increasing integration of health and social care provision.

The mental health service in England comprises a variety of organisations[mmmmmmmm] (see further). Mental health services can be provided through GP and primary care services or through more specialist care. The first point of contact for most people will be:

- Primary care services (GPs, outpatient clinics, counsellors), or
- Social services (for example, social workers).

These services often refer for specialist care when needed. This specialist care is normally provided by mental health trusts or local council social services departments. Services range from psychological therapy, through to very specialist medical and training services for people with severe mental health problems.

There are now 85 providers of secondary mental health services in England, including 18 primary care trust (PCT) providers.

- Mental Health Trusts - provide local specialist mental health services. They are commissioned to provide these services by PCTs. The PCTs commission healthcare from hospitals, GPs and others and pay them on an agreed tariff or contract basis, on guidelines set out by the Department of Health.

There are a number of other specialist agencies dealing with the provision and support of mental health care:

- National Institute for Mental Health in England (NIMHE) nnnnnnnn is organised in eight development centres. It has to put policy into practice, provide learning and development resources, and resolve local challenges. The organisation has three strategic priorities: (1) to ensure that the overall mental health care enables the provision of efficient and effective care and treatment (2) Workforce development – to ensure that there are sufficient staff, with the right skills, experience and leadership to provide the services needed (3) Changes in practice – to ensure that people have rapid access to the best possible care
- Local Implementation Teams - coordinate local plans and identify priorities in mental health services. Community services are coordinated and commissioned by local implementation teams (LITs), of which there are 174 in England. These teams pool the work of mental health trusts, health and social care trusts, primary care trusts, councils with social service responsibilities and local voluntary and independent healthcare sector services.
- Crisis Resolution Team - provide intensive support for people in mental health crises, in their own home.

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mmmmmmmm http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=566

nnnnnnnn http://www.nimhe.csip.org.uk/about-nimhe.html

- Community Mental Health Team (CMHT) - support people with mental health problems and their families in community settings; reduce the stigma associated with mental health care; ensure that care is delivered in the most suitable manner possible; provide support and advice to other healthcare services.

12.5.3 Residential mental health services

Most of the currently available mental health care hospital beds are acute or secure beds.

Secure facilities

Forensic mental health services (secure containment) deal with mentally ill people who may need a degree of physical security and have shown challenging behaviour beyond the scope of general psychiatric services. Some may be mentally disordered offenders. Services fall into three categories:

- low-security services tend to be based near general psychiatric wards in NHS hospitals
- medium-secure services often operate regionally and usually consist of locked wards with a greater number and a wider range of staff
- high-security services are provided by the three special hospitals, which have much greater levels of security and care for people who pose an immediate and serious risk to others. These institutions function outside the NHS management framework.

In addition, new services are developing to meet the needs of mentally disordered offenders in the community.

In recent years this has changed in two ways. Problems with the running of the high secure establishments have led to the transfer of their management to local mental health provider organisations. A detailed assessment of the patients in these institutions has led to a transfer to different settings. But in the same recent period the demand for low to medium secure accommodation increased in such a way that NHS could not answer this growing demand, leading to an expansion in the proportion provided by the independent sector.

Inpatient services

In-patient beds for acute illness

NHS beds form the main provision for in-patient treatment of acute illness.

Psychiatric hospital services have been progressively scaled down over the past 30 years, as many services once provided in hospitals are now provided in the community. The effect is that more severe mentally ill patients are helped in psychiatric wards, and that the length of stay is increasing compared to previous periods in history. Taking into account the population shift, major debates have taken place on the security and organisation of the psychiatric wards.

Hostels

Hostels accommodate 20 or more people and are managed either by local authority social services departments or voluntary agencies. They are regarded as short-term housing facilities, with the aim of promoting the residents' independence and supporting them with their mental health problems. Staff employed in hostels may include nurses, mental health support workers and residential social workers. In some cases, 24-hour support is provided. In others, an on-call system operates when staff have gone home.

People will generally require social services funding to enable them to pay for their place in a hostel. This usually applies whether the hostel is run by social services or by a voluntary organisation.

Hospital hostels

These accommodate 10-20 people and are designed to meet the needs of people with more severe mental health problems. Nursing care is provided on a 24-hour basis and links with hospital services are maintained.

Residential care homes

Residential care for people with mental health problems can be provided by local authority social services departments or voluntary organisations. These homes are staffed round-the-clock by residential social workers, nurses and mental health support workers. They offer a very high level of support for people with severe mental health problems who cannot manage in their own homes despite receiving community care services.

The funding for residential care comes from social services. This applies whether the home is managed by social services or by a voluntary or private agency.

Therapeutic communities

Therapeutic communities provide a supportive environment for rehabilitation. Accommodation is often shared and there are regular house meetings with the resident therapist. Different types of therapy, including counselling, may be provided. Stay is often limited to an agreed time period.

The funding for a place in a therapeutic community usually comes from social services departments or the NHS (although services are often arranged by other organisations, such as the Richmond Fellowship).

Supported housing and group homes

Supported housing schemes provide furnished accommodation for people who are able to live independently but appreciate the support of a mental health support worker. Group homes are similar, but involve a number of service users living together with additional support from a worker. Both types of project vary in relation to the level and amount of support they offer. Projects can be run by social services or voluntary organisations.

12.5.3.1 Day & structured activity services

Mental health day care is provided in many hospitals, usually in a separate 'day hospital' attached to the hospital psychiatric unit.

Day hospital care

Day hospital care is similar to the programme offered to inpatients and can include therapeutic activities, such as occupational therapy and group therapy.

Day hospitals are still part of mental health services, although the trend is for day care to be arranged outside hospitals by social services departments or voluntary organisations. Patients may be referred to the day hospital after being discharged from a psychiatric unit. Sometimes people are referred by the psychiatrist at the outpatient clinic or can be referred from other specialist services, such as the community mental health team.

Day care centres

The aim of day care is to provide recreation, therapy and rehabilitation. The company and support offered can ease the loneliness and isolation that often accompanies mental distress. Day care is usually provided in centres run by social services or voluntary agencies, such as Mind. Many day centres run by voluntary organisations accept self-referrals.

12.5.3.2 Outpatient and community mental health services

Primary care

The vast majority people who receive help for mental health problems are dealt with in primary care. Less than half of GPs have postgraduate training in psychiatry and only two per cent of practice nurses have mental health training, although about half of GP surgeries provide counselling.

GPs get incentives to provide care for the *physical* health of people with severe mental illness. GPs usually refer patients they cannot help directly to the local community mental health team (CMHT) or to a psychiatric outpatient clinic.

Community mental health teams

Community mental health teams(CMHT) [oooooooo] have been created in order to support and coordinate the care around service users with mental health problems. CMHTs - sometimes known as primary care liaison teams - are the main source of specialist support for those suffering severe and enduring mental health problems. They assess and monitor mental health needs using two specialist systems - the care programme approach or care management. These require that everyone seen by specialist mental health services should have their need for treatment assessed, a care plan drawn up and a named mental health worker to co-ordinate their care, including a regular review of their needs. They aim to provide continuity of care across services, promote multi-professional and inter-agency working, and ensure suitable care for people diagnosed with serious mental illness on discharge from hospital.

CMHT members include community psychiatric nurses, social workers, psychologists, occupational therapists, doctors and support workers. Patients will regularly meet the psychiatrist from their mental health team at a psychiatric outpatient clinic for review of their treatment.

Providing mental health services in the community has prompted new approaches to care to avoid hospital admission, such as:

- early intervention teams, which aim to treat psychotic illness as quickly and effectively as possible, especially during the critical period after its onset
- assertive outreach teams to provide intensive support for severely mentally ill people who are difficult to engage in more traditional services
- home treatment and crisis resolution to provide flexible acute care in patients' own homes with a 24-hour service to help with crises.

- **252 assertive outreach teams provide intensive support in the community to patients with complex health and social needs (eg drug misuse or offending as well as mental illness) who might otherwise drift out of care.**
- **118 early intervention teams providing young people, who have developed a severe mental illness for the first time, with rapid assessment and treatment.**[pppppppp]
- **343 crisis resolution (home treatment) teams offering an alternative to in-patient admission. Almost 100,000 people used these services last year.**

oooooooo http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4085759

pppppppp http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074241

Assertive outreach teams

England has about 250 recognised Assertive outreach team's, of which 207 meat the the 7 criteria of ACT. ACT teams aim to keep in contact with people who are 'difficult to engage with'. They are particularly concerned with those people who have severe mental health problems but who fail to take up aftercare once they have been discharged from hospital.

Assertive outreach teams will generally deal with people who have been in contact with specialist mental health services, either because they have been admitted to hospital or are experiencing mental health problems in the community. Specialist mental health services may refer someone to the assertive outreach team if he or she fails to take up the services on offer.

Outreach support/floating support

This type of accommodation is for people with fairly low support needs and is designed to encourage independent living. Mutual support between residents is encouraged.

The accommodation consists of individual flats allocated to an outreach support project within a particular area. Support is provided by a team of workers, often called 'outreach support workers' or 'floating support workers' who visit residents in their own flats. Workers can provide support with financial and practical matters relating to the home and refer residents on to other services such as counselling.

Crisis and Emergency care

A Crisis service is any service that helps a person to resolve a crisis, or that supports them while it is happening, can be seen as a crisis service. These services can range from telephone help lines and online discussion forums to Crisis Resolution Teams (CRTs) and hospital wards.

Crisis services can be provided by the public sector (NHS or Social Services) or the voluntary sector (charities or non-profit making organisations involved in health, social care or other forms of support). Within the NHS, crisis services may be provided by primary as well as secondary care.

Some areas have developed crisis intervention or resolution teams as part of their community mental health care service. These teams provide services either in the person's home or in another community setting (such as a staffed house). Crisis Resolution Teams (sometimes called Home Treatment Teams) are provided for adults (aged 18 to 65) experiencing an acute mental health crisis which, without the involvement of the Team, would be likely to result in hospitalisation. The aim of this service is to treat people in the least restrictive environment, with the minimum of disruption to their lives, and in their own home. Crisis Resolution Teams should provide immediate, community-based treatment 24 hours a day, seven days a week. This includes a rapid response following referral, intensive intervention and support in the early stages of the crisis and continuity throughout its management. The CRTs should work with family, friends and carers. They have a good knowledge of local services and can help the person in crisis to learn from the experience, in terms of crisis prevention and crisis management. If admission to hospital should prove necessary, the CRT should be involved in planning the discharge from hospital and providing intensive care to enable an early discharge.

CRTs contain staff from all disciplines that may be medicine, psychology and social work, as well as support staff that may include people with life experience of mental health problems and services.

Some health and local authorities provide 24-hour walk-in clinics, staffed by psychiatrists, nurses and social workers, and supported by the community mental health team in the daytime.

Crisis houses may have a small number of beds, often for a group with specific needs, for example, women, people from Black and minority ethnic communities or young people. Crisis houses aim is to provide community support in order to prevent hospital admission. Some services are open 24 hours, whilst others provide out-of-hours cover, but have specific closing times. Many crisis services have 24-hour telephone lines where a person can contact the service quickly.

For people facing problems of homelessness, formula's of emergency housing have been developed

Outpatient clinics

GP's can refer patients to outpatient clinics, in which psychiatrists are operating. The psychiatrist may prescribe medication or refer the patient on to other forms of treatment such as psychotherapy. They may also refer the patient to the community mental health team or admit him to hospital. Psychiatrists usually see people who have been admitted to a psychiatric unit or referred to the outpatient department by a GP. However, if the situation is urgent enough, the GP can ask the psychiatrist to visit and assess a person at home.

Drop-in centres or social clubs

Many areas have informal drop-in centres or social clubs where people can meet others who are in a similar situation and enjoy each other's company. This can be a way of keeping in touch with other people when more formal therapeutic activities are not needed, not suitable or unavailable. Most drop-in centres and/or social clubs accept self-referrals.

Befriending schemes

Befriending schemes help by putting people in touch will volunteer befrienders who are given training. Befrienders offer support and friendship on a one-to-one basis. Schemes are usually run by voluntary organisations.

Welfare rights/advice centres

Welfare rights and advice centres offer advice and support on a range of issues, including mental health, legal rights, employment and housing. (sometimes based in hospitals and social work departments) Some telephone help lines, such as NHS Direct and Mind*info*Line, can also offer advice on rights.

Respite care

Respite care projects provide short-term supported accommodation for people who need a high level of support for a short time or to provide a break for carers. Some care homes and nursing homes also provide some respite care.

12.5.3.3 Specific programmes

Services in the UK are sharply delineated into those for working age adults (aged 18–64), for older adults, and for children and adolescents. This separation is reflected in the policy-making of the Department of Health where older adult and child and adolescent services are the responsibility of age-defined policy branches, while services for working age adults are managed by a mental health policy group (Glover 2007)[223].

12.6 FUNDING OF MENTAL HEALTH CARE

As a proportion of NHS spending, mental health spending has been stable at 8-9% over the years[qqqqqqqq]. Spending by health and social services rose by almost £1 billion – around 25% - in the four years from 2001-2. Mental health as a proportion of the total local purchaser allocations (2003) varied from 22.5% to 8.1%, around an average of 11,6%. Some of this variation is due to the additional finance provided for remaining long stay-institutions.

The National Service Framework (1999) set out a number of new funding allocations to support mental health service development. It stressed the central role of mainstream NHS funding, and observed wide variations in local per capita funding of mental health services by statutory agencies, partly explicable by historical factors such as the presence of old asylums. However it asserted that these funding variations could contribute to unacceptable variations in the quantity and quality of services provided. It stated that resources should be allocated in line with population based need for services.

The reforms lead in 2003 to changed calculation and allocation of budgets. As part of the new allocation process for primary care trusts for 2003/4 and later years, a new set of healthcare need indices was introduced. The new index for mental health care is based on more recent data than its predecessor and contains a number of methodological innovations The figures it produces for relative need levels differ considerably from those of its predecessor. The Department of Health is attempting resource allocation in line with population based need for services, set out in the National Service Framework.

The largest part of mental health care in England is provided through the National Health Service. 80 % of NHS spending on mental health is devoted to inpatient services.

Recent years have witnessed a gradual rebalancing of responsibility from National Health Service (NHS) to local authority budgets in financing mental health services in the United Kingdom. Local authorities have assumed responsibility for funding placements, such as in nursing homes, residential care homes and supported accommodation, that previously would have been paid for by the NHS or covered by social security transfers. As a consequence, in the last few years, expenditure on mental health services by municipalities has grown faster than NHS spending, accounting today for roughly one fifth of its size. This proportion varies substantially across the country. For instance, social services spending on mental health by local authority in London ranges from 23% to 79% of health service spending (Moscone 2006)[224]. Local purchasers are free to spend more or less on mental health than determined by the mental needs allocation, but in providing services, local planners must ensure that services are available that meet the needs of the National service Framework of mental health, ensuring that resources are targeted in evidence based ways to mental health. Small amounts of additional money for mental health can be earmarked through special allocations (e. g. mentally disordered offenders) and to implement mental health aspects of the NHS plan.

qqqqqqqq www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074241

13 AUSTRALIA

13.1 LITERATURE SEARCH: METHODOLOGY

See general methodology. No information (references, data…) has been included after August 15, 2010.

13.2 ORGANISATION AND FINANCING OF THE HEALTH CARE SECTOR

13.2.1 Organisation of the Australian health care system

Since 1901, Australia has become an independent nation with a federal system of government (in line with the British Westminster system of government and law) with 22.3 million inhabitants (12 August 2010). The Commonwealth Government is subdivided in six States and various Territories. The states and three of the territories each have their own parliament with specific responsibilities, the remaining territories are administered by the federal government.

The Commonwealth makes policy concerning national issues, like public health, research and national information management and regulates the residential aged care, which is provided by the non-government sector. The States and Territories are responsible for public acute and psychiatric hospital services and community and public health services.

Also non-government religious and charitable organisations play an important role in health services, public health and health insurance.

Due to the specific characteristics of Australia's history and needs, some unique solutions were set up, like the Royal Flying Doctor Service, specific health services for Aboriginals (407.700 Aboriginals in 2009) and Torres Strait Islander people (29.512 Torres Strait Islander people in 2009) and regional health services (in rural and remote areas).

13.2.2 Financing principles of health care

Health care in Australia is generally considered to be of high quality, affordable and accessible to all Australians. The national health care funding system, called Medicare, is largely financed from general taxation revenue. The individual contributions are based on income and are paid by taxation levy (the Medicare levy).

In 2003-2004, 70% of the total health revenue came from taxation, the remaining 30% from private sources. The out-of-pocket payments accounted for 20.3% of total health expenditure[225]

Medical health care is largely subsidized by Medicare, involving free treatment for the public patient in a public hospital, free treatment by general practitioners and specialist of the choice out of the hospital and the subsidizing of essential pharmaceuticals. The amount of medical services per individual is not limited. A list of medical services is not subsidized by Medicare, such as long-term care, occupational therapy, treatment by psychologists, private allied health services etc. Some of these services can be covered by private health insurance funds[225].

The Medicare Benefits Schedule contains a list of consultations, procedures and tests and the related fee. Notwithstanding this listing of medical fees, doctors are free to charge their price, except for the bulk-billed services. The majority of Medicare expenditure is for general practice services, pathology and diagnostic imaging tests and specialist consultations[225].

13.2.2.1 Hospital care

Patients may choose to be treated as public patients, giving them the right on free medical and allied health/paramedical care from doctors nominated by the hospitals and free accommodation. All costs are then reimbursed by Medicare. The patients, who want to be treated as private patients in public hospitals, are free to choose their doctors; they will be charged fees by doctors and by the hospital for hospital care. The same is true for patients in a private hospital. These costs are covered by the private health insurance funds[225].

13.2.2.2 Ambulatory care

General practice is the main form of medical practice (60% of the active medical practitioners in 2005). Most general practitioners are self-employed, mostly solo practices, but their fee-for-service shifted from private to public source (Medicare). Some programs are set up to improve the quality of care: practice incentive program (PIP) to improve the quality and accountability of the medical services and Enhanced Primary Care (EPC) to provide more preventive care for the elderly[225].

Also other health care professionals provide primary care, like nurses and allied health professionals.

13.2.2.3 Private insurance

The private health insurance covers public and private hospital charges, a part of the medical fees for inpatient services, allied health/paramedical services and some aids and appliances.

Primary medical care is not covered by private insurances[225]. Since the introduction of Medicare, the private health insurance funds are not allowed to reimburse the out-of-hospital medical services provided by medical practitioners. However some items, not covered by Medicare, can be reimbursed by the private insurances (like dental and optical services).

The Commonwealth promotes the membership of a private health insurance by offering financial incentives[225], leading to a coverage of 43.1% in 2005.

13.2.3 Support services for people with disabilities

The Commonwealth State/Territory Disability Agreement (CSTDA) provides the framework for the state and territory government to supply specialist support services to people with disabilities[226]. The Australian government is responsible for the planning, policy setting and management of employment services, the states and territories are responsible for all other disability services.

Definition of a disability is a disability attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury, which is permanent and leads to a reduced capacity in self care, mobility and communication. The needs should be significant and require long-term support and the disability must manifest before the age of 65 (CSTDA).

Services may be residential or non-residential or the combination of both (further description in service tree). Between 2005 and 2007 the use of CSTDA-funded services by people with a psychiatric disability increased with 25%.

Overall, psychiatric disability is reported as the second most common disability (15% of CSTDA service users, 47 658 people), next to intellectual disability (33%) and ahead of physical disability (13%) (2006-2007, CSTDA National Minimum Data Set).

13.3 ORGANISATION OF THE MENTAL HEALTH CARE IN AUSTRALIA

13.3.1 General organisation of the mental health care

The specialised mental health care is provided in 6 types of facilities (number of facilities and beds in 2006-2007, for a population level of about 22 million inhabitants)[226]:

- Public psychiatric hospital (16 hospitals, 2211 beds)
- Private psychiatric hospital (25 hospitals, 1554 beds)
- Psychiatric unit or ward in public acute hospital (139 units, 4196 beds)
- Community mental health care service (932 services)
- Government-operated residential mental health service (81 services,1490 beds)
- Non-government-operated residential mental health service (56 services, 675 beds)

Other types of facilities exist, e.g. alternative models of accommodation support are being developed. However, only limited information on these is currently available[227].

As in all Western countries, a deinstitutionalization movement took place in Australia in the second half of the 20th century, and it continued at the beginning of the 21st century. Between 2002-03 and 2006-07 a shift (in number of facilities and number of beds) from psychiatric hospitals towards specialised units or wards in acute general hospitals took place. Also the number of government-operated residential mental health services has increased (with an annual increase of 12.8%) (see also further).

The delivering of specialised mental health care can consist of acute and non-acute care and can be focused on target groups, such as children and adolescents (aged under 18 years), elderly (aged 65 years and over), adults with a forensic component and the general adult group.

In public hospital specialised mental health care services the majority of health care is provided to adults and to a lesser extent to older person services (16.4%), to forensic services (9.4%) and to child and adolescent services (4.3%).

The residential mental health care services (2 165 beds) are characterised by the service operator (government or non-government), the level of staffing (24-hour period or less) and the focus on adults and older persons.

13.3.2 Recent reforms

13.3.2.1 The National Mental Health Strategy

Historically, the provision of mental health care has been a responsibility of the state government. Australia's national government showed little interest in mental health care until 1992. In 1992 all Australian Health Ministers endorsed the National Mental Health Strategy (NMH Strategy), a visionary framework on improving mental health care throughout the country. They committed their governments to participate in the reform process. Since then, this NMH Strategy has guided a continuous process of change in mental health care throughout the country.

The National Mental Health Strategy consists of:

- the National Mental Health Policy (NMH Policy), which sets out the overall framework. The NMH Policy was first formulated in 1992 and revised in 2008;
- National Mental Health Plans (NMH Plans), intended as implementation guides. Each plan runs for 5 years, and is followed by a thorough evaluation process; the Fourth plan runs from 2009 to 2014;
- the Mental Health statement of Rights and Responsibilities

This statement embodies the values of the United Nations Resolution of the protection of rights of people with mental illness.

Additionally, but always in line with the National Mental Health Strategy, other Plans and frameworks have been launched:

- the Council of Australian Governments (COAG) National Action Plan on Mental Health, endorsed in 2006 (description see below),
- State and Territory Mental Health Plans and Frameworks

13.3.2.2 Plan evaluation

Each NMH Plan is followed by a thorough evaluation, and open communication on the results is one of the explicit aims of the reform. Also other Plans, like the COAG National Action Plan, are critically evaluated and the results are made publicly available.

To realize these evaluations, necessary data is collected through several databases and made publicly available (e.g. "Mental health services in Australia 2006-07"[226]). The strength of this data collection is based on three factors. First, on its uniformity throughout the country for health care data as well as for data on disabilities, notwithstanding the organization of Australia in States and Territories. Second, on its extensiveness regarding included topics (e.g. number of persons with mental disorders using employment support services). Third, on the fact that for ambulatory as well as for residential mental health services outcomes are recorded based on validated outcome scales (e.g. the HoNOS scale) and reported in double by professionals and by service users[rrrrrrrr]. The strength of the reports that are published based on this data, lies in the combining of data of different sources: e.g. "Mental health services in Australia 2006-07" [226] combines data on mental health care as well as on chronic care for persons with a mental disorder; data from the Commonwealth are included as well as data from States and Territories. Still, data collection is under constant revision and adaptation, to further improve it.

Starting from this impressive data collection, a critical evaluation is disseminated on a regular basis in the National Mental Health Reports; the tenth report (2007)[227] of this series gives an overview of the available material for the period 1993-2005. Further, each five years two independent internationally recognized experts on mental health services organization evaluate the changes introduced by the previous NMH Plan. This evaluation is mainly based on site visits and extensive consultation rounds with professionals as well as service users and other stakeholders, and it also comprises a review of official documents published on the subject.

13.3.2.3 Scope of this chapter

In this chapter we mainly focus on the evaluation report of the third national mental health plan and the priority themes of the fourth (and latest) national mental health plan. The Council of Australian Governments (COAG) National Action plan will also be discussed. Finally, the "Better Access program" and the initiative "Access to Allied Psychological Services (ATAPS)" will be presented, both parts of the 3rd NMH Plan deserving special attention. Lastly, experimental projects aiming at integrating public mental health services or GP practices with private psychiatrist services will be presented.

13.3.2.4 Third National Mental Health Plan 2003-2008

The Third National Mental Health Plan (2003-2008)[228] builds further on both the first and the second plan and aims to identify priority areas of work within an agreed policy framework. In this paragraph, the summarised results of the evaluation of this plan[229] are added to the description of the priority themes.

The four priority themes of the plan are:

[rrrrrrrr] Australian Mental Health Outcomes and Classification Network (AMHOCN), see www. amhocn.org

Promoting mental health and preventing mental health illness

This theme aimed to improve prevention, also included were improvement of early intervention, a decreased level of stigma, and recovery orientated mental health services.

Evaluation of the third mental health plan indicates an increased level of awareness around specific mental health problems. One example of a new initiative is Beyond Blue (decline of the stigma around depression). New Early Intervention Services for Parents, Children and Young People and the Better Access initiatives are examples of the implementation of early intervention as key component of the COAG Action plan (see further) in specific intervention programmes.

Increasing service responsiveness

The 3 pillars of this theme are: access to care, continuity of care[sssssssss] and support for family and carers. The initiatives in the third NMH Plan around the issue of access to care had to comprise an improved access to mental health services (community-based care alternatives, supported accommodation etc.), and an improved access to health care providers (GPs, private psychiatrists) (see further 1.2.2.7). Initiatives to improve continuity of care had to be set up to enhance care pathways and to reduce the service systems gaps, resulting in an improved coordination within mental health services an between mental health sector and other areas of health. The role of non-government organisations in the support of consumers, families and cares had to be developed and recognised.

Evaluation shows a more integrated service system nationally, mainly due to an increased funding (4 billion dollars attached to the COAG Action Plan for all mental health services). However, the evaluation report does not give more details on how this integration had been realized and what patient outcomes were.

Strengthening quality

According to the 3rd NMH Plan, strengthening the quality of mental care should be obtained by the guarantee of consumer rights and legislation, consumer and carer participation, improving safety, developing service standards and monitoring outcomes nationwide, increased funding and increase of workforce. The evaluation indicates a progress of the quality standards, but on the other hand the lack of workforce affects the quality of service and service delivery. Also little progress is made on the integration of services for specific subgroups. The reduction and elimination of seclusion and restraint is not yet systematically implemented. The Mental Health Working Group (see further) set up a consumer and carer forum in order to develop new pathways of communication between consumer and carer and to government officials. Notwithstanding these initiatives, the evaluation estimates that more and varied structures of consumer and carer voices need to be developed.

Fostering research, innovation and sustainability

Evaluation indicates improvements in the funding of the government in research programmes to monitor mental health and the outcomes of care. But on the other hand the research agenda is not clearly defined or prioritised. Also the way of access to the information is not yet user-friendly.

General conclusions of the evaluation emphasized the need for a further NMH Plan to maintain and focus momentum for better mental health care. However, the new NMH Plan should give specific guidance towards actionable and prioritized items, rather than being exceedingly broad by trying to "be all things to all people". The recommendations with the highest priority involved action around workforce, housing and employment, actions for underserved groups (such as the prisoners), anti-stigma interventions, consumer and carer participation, developing a system to monitor performance of services, and a coordinated whole of government approach.

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sssssssss This topic has also been elaborated in the CAOG National Action Plan on Mental Health (2006), see further.

The results and recommendations of the evaluation report are integrated in the fourth national mental health plan (2009-2014).

13.3.2.5 The Fourth National Mental Health Plan (2009-2014)

The Fourth National mental Health Plan (2009-2014)[230] defines 5 priority areas, and also defines their key outcomes and measurable outcome indicators.

Priority area's are: Social inclusion and recovery; Prevention and early intervention; Services access, coordination and continuity of care; Quality improvement and innovation; Accountability-measuring and reporting progress.

The Plan deals with topics on the patient level, the service level and the level of the administration. The most important are listed below.

On the patient level

- early intervention programs
- housing programs
- education, employment and vocational support
- support for families and carers
- a national stigma reducing campaign

On the service level

- coordination and continuity of care between primary and specialist mental health services; and between mental health care and general community services, housing, justice.
- involvement of consumers and carers in planning and evaluation of services
- further improvement of innovative services such as e-mental health

On the level of administration

- development of a national service planning framework
- development and commencement of a strategy to ensure sufficient and competent mental health care workforce in the future
- further development and implementation of the National Standards for mental health services and the National mental health Performance and benchmarking framework (quality and performance indicators).
- development of a national mental health research strategy, including indication of priority domains
- necessary amendments to mental health and related legislation.

13.3.2.6 The National Action Plan on Mental health 2006-2011

To address specific remaining service gaps not included in the National Mental Health Plans, the Council of Australian Governments (COAG) has developed a National Action Plan on Mental Health[231]. This framework (2006-2011) especially focuses on the coordination and collaboration between government, private and non-government providers towards a more seamless and connected care system for people with a mental illness. The national action plan, directed to the Commonwealth, State and Territory governments, describes four general outcomes translated into five areas for specific action, and agreed between the governments. The national action plan is yearly evaluated based on "progress measures". The latest version (the second progress report[232] describes the initiatives in the period 2007-2008. These initiatives lead to a substantial growth in services and a spending of approximately 4 billion AUD in 2007-2008, representing an additional 17% of the total annual base spending of the Australian Governments on mental health care. It will be equivalent to 20 billion AUD over the 5-year of the action plan.

In the evaluation of the progress of the Plan, 12 progress indicators (e.g. prevalence of mental illness in the community, percentage of people with a mental illness who receive mental health care, the rates of community follow up for people within the first seven days of discharge from hospital) are identified to detect the improvements. (For more details, see reference[232]).

The five areas for action are:

- Action area 1: Promotion, prevention and early intervention (10% (562.3 million AUD) of the total action plan commitments).
- Action area 2: Integrating and improving the care system (67% of the total action plan commitments (3.7 billion AUD).
- This action area emphasizes the necessity of adequate resources for health and community support services so that they are able to meet the level of need. Further, it emphasizes the role of coordination, by developing two "flagship" initiatives (care coordination and governments working together) (see also action area 5).
- Action area 3: Participation in the community, including accommodation and employment, by effective community-based support and by supporting carers (17% (944 million AUD) of the total action plan commitments).
- This action area emphasizes the role of services outside the health sector to provide support to live independently and participate fully in community life. It intends to increase the development of support services in the community, focusing on employment, accommodation and services to assist carers.
- Action area 4: Increasing mental health work force capacity (5% (277 million AUD) of the total action plan commitments)
- Besides a general increase the mental health work force capacity, the critical role of primary care as complementary to the specialised public mental health services is also emphasized.
- Action area 5: Coordinating care on patient level (e.g. by a care coordinator) and on policy level (by COAG Mental Health Groups)

The initiative "coordinating care" on patient level contains several aspects, such as the set up of a new system whereby a care coordinator is appointed to each person with severe mental illness, to ensure that the person is connected to the health and community services to maintain his life in the community .

Under the initiative of governments working together, COAG Mental Health Groups were formed with representatives of government department, non-government organisations, the private sector, consumer and carers in order to create forums for oversight and collaboration in planning and the implementation of the initiatives under the action plan. Also the implementation of guidelines (developed in the first year of the action plan) is a task of the COAG Mental Health Groups, in order to facilitate the care coordination model.

No extra funding is reserved for this action area, which is integrated in the existing resources (for example the second action area).

13.3.2.7 Primary care in General Practice: the Better Access program

In order to improve access to mental health care, GP Mental Health Care Items were included in the Medicare Benefits Schedule (Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative). The Better Access initiative is a core element of the COAG National Action Plan on Mental Health 2006-2011 (see description above).

The main objectives of these items are the provision of a structured framework of best practice primary health care (GP, psychiatrists, psychologists) to patients with a mental health problem and the provision of referral pathways to clinical psychologists and other allied mental health care workers[226].

Overview of the three GP Mental Health Care Items:

- Preparation of a GP Mental Health Care Plan

This item includes the assessment of a patient, preparation of a GP Mental health Care Plan (with the treatment options) and the referral to mental health care professionals. The management of the patient involves one plan per patient and continuing consultation and review services.

- Review of a GP Mental Health Care Plan

The GP can review the patient's progress after the completion of the GP Mental Health Care Plan (at least once)

- GP Mental Health Care Consultation

This item includes the reimbursement of the GP and the patient for an extended consultation (at least 20 minutes), mostly used for the continuing management of a patient with a mental disorder.

Medicare provides, for patients with a GP Mental Health Care Plan, 12 rebates per calendar year for individual services and 12 rebates per calendar year for group services.

Besides the improved access to mental health care services (by the inclusion of GP Mental Health Care Items in the MBS), GPs are also strongly recommended to follow training in mental health care, recognised by the General Practice Mental Health Standards Collaboration.

The evaluation of the Better Access program in 2009 indicates the rapid uptake of the program by the GPs (e.g. a budget of 753million AUD in 2008-09); however some subgroups (like Indigenous Australians) remain underserved[233]. In a survey of general practice activity across Australia, 10.8% (an estimation of 11.9 million AUD) of all GP encounters were mental-health related encounters in 2007-08; with an annual increase of 1.1% between 2003-04 and 2007-08. The three most common mental health-related problems were depression (34.7%), anxiety (15.4%), sleep disturbance (14.1%). In 12.1 per 100 mental health-related problems, a referral was given to psychologists (5.5 per 100), psychiatrists (1.9 per 100), and others.

Besides these changes for GPs, the Better Access program also included specific financial incentives for psychiatrists, psychologists, and other allied mental health professionals, all with the same aim: to improve access to mental health care by integrating allied health and GP care in the already existing care circuits[233].

13.3.2.8 The initiative "Access to Allied Psychological Services"

The initiative "Access to Allied Psychological Services (ATAPS)" is part of the Better Access to Psychiatrists, Psychologists and General practitioners through the medical Benefits Schedule (Better Access) program and funds the provision of short term psychology services for people with mental disorders.

The ATAPs program enables the GPs to refer patients with high prevalence mental disorder to allied health professionals for six sessions of evidence based mental health care. Between July 2003 and March 2009, 153.000 consumers were referred by GPs to ATAPS services, with an average of 5 services per consumer. Profile of the most common consumer is a female, mean age 39 years and suffering from a high prevalence mental disorder (such as depression and anxiety)[234].

13.3.2.9 The "National Mental Health Integration Program"

Three experimental or "demonstration" programs were funded in 1999, aimed at improving linkages between private psychiatrist services and public sector mental health services, GPs or NGO's. The purpose was to create a more flexible, integrated service delivery framework. An overall evaluation has been published by Eagar et al (2005)[235]. Most proposed services were "shared services" (see chapter 4.1.1.5 and 4.5.2.4 in this report) that also provided remuneration for psychiatrist participation in specific tasks such as case conferencing, supervision etc, and some budget flexibility to meet organizational and administrative costs.

Each demonstration project included several subprojects, and each site could build its own shared care model, to fit local needs. A management team for each project and a national reference group had to support the projects. All three projects involved careful planning and local leadership representing different interests. The systems needed to operate smoothly to engage and maintain provider's commitment, and it was recognized that enormous efforts were required from the part of the project teams. Integration seemed feasible, and although patient outcomes were diverse and difficult to synthesize due to the use of different measures, some reductions in clinical symptoms and levels of functioning were noticed. In general terms, the health insurance costs were contained, but caution had to be exercised in interpretation because of possible confounders. Overall, emphasis on communication and collaboration between the different parties as well as cultural changes, together with adapted funding possibilities, were seen as necessary elements to generalize and sustain the results of the projects. Moreover, it was recognized that continuous efforts would be necessary to maintain the projects' results.

13.3.3 Mapping of the existing services: introduction

We use the 'Service Tree' developed by Johnson et al. to map the mental health services[5]. This 'Tree' distinguishes five main different structures of mental health services: secure, residential, day & structured activity, out-patient & community and self-help & non professional services. The second, third and fourth structures are developed as a tree to take into account the differences between acute and non-acute care, emergency and continuing cares but also the duration, the intensity and the mobility of the cares or activities.

We present a synthetic table of all the existing services applying the ESMS tree and we describe the organizational and financial aspects of each of them in the following sections. We distinguish '**Full mental health services**' which is a matter for the psychiatric sector, from the **Mixed services** ('Residential mixed services' and 'Mixed support teams'). We find 'full mental health services' in all the categories of the Service Tree developed by Johnson. Residential mixed health services and mixed ambulatory support health and social teams concern a broader group of patients or persons knowing social problems.

Table: Synthetic presentation of the ESMS tree

SECURE **(1)**			
RESIDENTIAL	Generic acute	Hospital **(2)**	
		Non-hospital **(3)**	
	Non-acute	Hospital **(4)**	Time limited **(4.1)**
			Indefinite stay **(4.2)**
		Non-hospital **(5)**	Time limited **(5.1)**
			Indefinite stay **(5.2)**
DAY & STRUCTURED ACTIVITY	Acute **(6)**		
	Non-acute **(7)**	High intensity **(7.1)**	
		Low intensity **(7.2)**	
OUT-PATIENT & COMMUNITY	Emergency care **(8)**	Mobile **(8.1)**	
		Non-mobile **(8.2)**	
	Continuing care **(9)**	Mobile **(9.1)**	
		Non-mobile **(9.2)**	
SELF-HELP & NON-PROFESSIONAL **(10)**			

13.3.4 The mental health tree in Australia

The main source for this paragraph are the report[226] on Mental Health Services in Australia, 2006-2007; and the National Mental Health Report (2007)[227].

A table with an overview of available services in Australia is presented in chapter 14.1.6.

13.3.4.1 Secure (1)

Secure services as such will not be addressed in this report, as they are out of the scope.

13.3.4.2 Residential services (acute and non-acute)

1. Generic acute
    a. Hospital (2)

By definition, hospitals belong to the "full mental health services" (see introduction). Between 1993 and 2005 the number of acute psychiatric beds remained relatively stable (~4000 places). However, the percentage of this type of beds in the general hospitals raised from 55% to 84% (3683 places), the rest remaining in the 16 stand alone psychiatric hospitals[227]. Of all public psychiatric beds (a total of 6407 beds in 2006-2007), 4196 beds are located in 139 public acute hospitals with a specialised psychiatric unit or ward, and 2211 beds in 16 stand alone psychiatric hospitals[225]. This implies that in 2005-2007 most places in public acute hospitals with a specialised psychiatric unit are acute beds, and most places in stand alone psychiatric hospitals are beds for longer term care.

Specialised admitted patient mental health care (= "specialised psychiatric care")

A mental health-related admission ("separation" in the National Hospital Morbidity Database or NHMD) is based on a mental health-related principal diagnosis and includes any specialised psychiatric care. If the patient is admitted in a specialised psychiatric unit or ward (i.e. in a public acute hospital with a specialised psychiatric unit or in a stand alone psychiatric hospital), the separation is defined as specialised psychiatric care (no subdivision is made between acute or longer term care). In 2006-2007, 58.3% of the mental health-related separations involved specialised psychiatric care. Demographical analysis shows the most common profile of a patient in specialised psychiatric care as an Australian-born, non-indigenous male aged 25-44 years who had never been married, and is mostly diagnosed with schizophrenia or depressive episode. The rate of admitted patient separations (not number of patients) is 5.9 per 1000 population.

Additionally, in 2006-2007, 41.7% of all the mental health-related "separations" (admissions, see further) involved mental health-related separations *without* specialised psychiatric care, mostly in public acute hospitals (87.8%) with a national average length of stay of 5.4 days[226]. The highest proportion and number of separations per 1000 population is found in the age group 65+ (24.8%). The most common principal diagnosis were mental and behavioural disorders due to the use of alcohol (20.1%) and depressive episode (13.8%) (and dementia (5.8%) in the age group of 65+).

b. Non-hospital (3)

The CSTDA (Commonwealth State/Territory Disability Agreement, see further)[226] provides services to people with different types of disabilities ("mixed services", see introduction). One of their services includes "accommodation support". Crisis accommodation support can be one of the services provided under this label. In 2006-2007, 45 persons with a psychiatric disability per 100 000 population used "accommodation support".

2. Non-acute

a. Hospital (4)

By definition, hospitals belong to the "full mental health services" (see introduction).

Ambulatory-equivalent mental health-related admitted patient care

In Australia, probably as a consequence of the large distances in this country, ambulatory care services can be provided to patients during hospital admission ("separation"), and are then considered "equivalent to community and hospital-based ambulatory care" (see (9) continuing care).

In 2006-2007, 36.6% of all mental health-related separations were ambulatory-equivalent mental health-related separations, corresponding to a rate of 5.7 per 1000 population.

Specialised admitted patient mental health care (= "specialised psychiatric care")

In 2006-2007, 58.3% of the mental health-related separations involved specialised psychiatric care (no subdivision is made between acute or longer term care); for the demographic analysis see "Generic acute". (For "non-specialised admitted patient mental health care", see also "Generic acute").

According to the national Mental Health Report 2007, the overall number of psychiatric beds decreased by roughly 22.000 since the beginning of the deinstitutionalization movement (1960s). Between 1993 and 2005, the reduction in the size of public stand alone psychiatric beds amounted to 66%. For a total of 6407 public beds in 2006-2007, 4196 beds are located in public acute hospitals with a specialised psychiatric unit or ward (mostly acute beds, see above), and 2211 beds in stand alone psychiatric hospitals (mostly beds for longer term care)[225]. Apart from these beds in public hospitals, there are another 1554 beds in 25 private psychiatric hospitals (2006-2007)[226]. In contrast to a relatively constant total number of acute beds since 1993, there has been an impressive further reduction in non acute beds from public stand alone psychiatric hospitals by 2205 places, or about half of the 1993 capacity. The 24-hour staffed (non-hospital) residential beds have increased by 583 beds or 71% (mainly due to a initiative in Victoria), equivalent to about one quarter of the reduction on long stay beds in stand alone hospitals. Notwithstanding the transfer of the psychiatric beds to other settings, it can be assumed that the provision of longer term care for people with serious and ongoing mental illness has been affected. The Mental Health Report 2007[227] could not yet comment on alternative treatment options in the community, due to a lack of information.

Major differences can be found between the different jurisdictions concerning the mix and level of psychiatric beds (Mental Health Report 2007[227]).

When refining the total number of 6407 public hospital beds, and excluding beds for children, elderly and forensic patients, it becomes clear that beds for adults (18-65 years) in amount to 70% (4484/6407) of the total public offer in 2006-2007, or 20,4 beds/ 100.000 population. These are 3218 acute places (14,6 / 100.000 population) and 1266 non-acute places (5,8/ 100.000 population) (Australian Institute of health and welfare 2009 p135)[226].

Apart from the 6407 public hospital beds, there are 1554 beds in private hospitals. If assumed that the proportion of adult beds amounts to 70%, the public sector alike, this would mean 1088 adult beds (4,9 beds/ 100.000 population). No information is available on the distribution of acute versus non-acute beds in the private sector.

All beds in public and private sector together: 7961 beds, or 36/100.000 population. Bed supply in general hospitals: 4196 or 53%; bed supply in psychiatric hospitals: 3765 or 47%.

b. Non-hospital (5)

Residential full mental health care (24h support and lower than 24h support)

Residential non-hospital mental health care covers a specialised mental health service by mental-health trained staff on site, providing rehabilitation, treatment or extended care to patients in a residential setting. In this domestic-like environment the patients will be encouraged to take responsibility for their daily living activities.

Nationally 1206 mental-health related residential care beds are available (2005) for adults (18-65 years), or 5,6 places/100.000 population. This includes 655 beds (3 places/100.000 population) with 24-hour period mental health-trained staff, the remaining 573 beds (2,6 places/100.000 population) are located in settings with mental-health trained staff between 6 and 24hours[227]. As already mentioned, the 24-hour staffed residential beds have increased by 583 beds or 71% (mainly due to an initiative in Victoria) between 1993-2005. An additional 772 places are available for elderly, almost exclusively with 24-hour period staff. Adults and elderly account together for 1978 places or 9.0 places/100.000 population (2005, governmental and non-governmental places together).

Another type of residential mental health care[227] are *supported housing places*: public sector accommodation places specifically provided for mentally ill persons, under an agreement between state/territory housing and health authorities, and including outreach services in their homes. In 2005, there were 3625 such places available (16,5 places/100.000 population).

Residential mixed services (24h support and lower than 24h support)

These services are provided by the CSTDA (Commonwealth State/Territory Disability Agreement)[230] to people with different types of disabilities.

CSTDA services may be residential or non-residential or the combination of both. Between 2005 and 2007 the use of CSTDA-funded services by people with a psychiatric disability increased with 25%. Overall, psychiatric disability is reported as the second most common disability (15% of CSTDA service users, 47 658 people), next to intellectual disability (33%) and ahead of physical disability (13%) (2006-2007, CSTDA National Minimum Data Set). The most common primary disability for users of *residential* CSTDA services is intellectual disability (79%), and the second most common is psychiatric disability (10%).

The residential mixed services can be organized as:

- Large or small residential institutions: 24-hour residential support, more than 20 beds (large) or 7-20 beds (small)
- Hostels: no 24-hour residential support, less than 20 beds
- Group homes: staffed 24 hours per day, combination of accommodation and community-based residential support, no more than 6 users in one service

The residential services are nationally used at a rate of 16.3 clients per 100 000 population (or 1.6 client with psychiatric disability per 100 000), of which the group homes are most widely used (70.9%). Demographic analysis show a majority of male users (58.2%), aged 35-54 year (55.2%).

Other services provided by the CSTDA (Commonwealth State/Territory Disability Agreement)[230] are called "*non-residential CSTDA services*", but nevertheless provide "accommodation support". Accommodation support aims to provide support with the basic needs of living, helping the person to remain in his current living arrangement by providing personal care by an attendant, in-home living support, alternative placement and crisis accommodation support. The rate of CSTDA-funded non-residential service users with a psychiatric disability is (in 2006-2007) nationally 224.7 per 100 000 population, of which nearly 20% (or 45 per 100 000 population) concerns accommodation support.

The non-residential CSTDA-funded services provide also respite services for caregivers of people with a disability. This service is a short-term and time-limited break and includes services similar as in the home situation, in centres, in respite homes and with host families. The rate of CSTDA-funded non-residential service users with a psychiatric disability is (in 2006-2007) nationally 224.7 per 100 000 population, of which nearly 9% (or 25 per 100 000 population) concerns respite care.

13.3.4.3 Day and structured activity

1. Acute (6):

No specific information found

2. Non-acute (7):

These services are provided by the CSTDA (Commonwealth State/Territory Disability Agreement)[230] to people with different types of disabilities, so they are "mixed services" (see introduction). The most common primary disability for users of non-residential CSTDA services is psychiatric disability (75%) (2006-2007, CSTDA National Minimum Data Set). The rate of CSTDA-funded non-residential service users with a psychiatric disability is (in 2006-2007) nationally 224.7 per 100 000 population.

The services can be:

- Community access services

These services include learning and life skills development, recreation and holiday programs, designated to gain and use the abilities for social independence. The rate of CSTDA-funded non-residential service users with a psychiatric disability is nationally 224.7 per 100 000 population, of which 30% uses community access services (69 per 100 000 population).

- Employment support services

The rate of CSTDA-funded non-residential service users with a psychiatric disability is nationally 224.7 per 100 000 population, characterised by the highest percentage for employment services (52.9%, or 119 per 100 000 population).

Other non-residential services provided by the CSTDA are accommodation support, community support and respite care, which are discussed elsewhere.

13.3.4.4 Outpatient and community mental health services

1. Emergency care(8)

Community-based emergency care ("full mental health service", see introduction) can be divided in three services: triage, crisis assessment and treatment (CAT team) and the enhanced crisis assessment and treatment (ECAT)[236].

The initial assessment of people in need of assistance occurs by the mental health telephone triage function. It is a 24 hours, 7 days per week service and it has a specialised screening, advisory and support role. The basic form refers the person to the correct mental health service, the more advanced services are staffed with mental health professionals who spend time assisting the people by advising.

Crisis assessment and treatment (CAT) is a community-based outreach service for assessing and treating people in the acute phase of their mental illness. The service includes short-term treatment in the community and gate-keeping function for access to inpatient services. The CAT services vary in size according to the geographical area (from 12-14 EFT to 20-22 EFT) and operate as part of the community mental health services. In the "1994 CAT Guidelines", the CAT[ttttttt] is described as a 24-7 service, but in reality people in need for overnight psychiatric assistance, need to call their local emergency department. Also, a critical evaluation of the CAT system learned that a more coordinated network of emergency services, police, ambulance and mental health services needs to be set up.

The triage system is underdeveloped, resulting in non-acute assessments by the CAT, which is out of the scope of this service. Also the specialist psychiatric telephone crisis counselling by CAT is in conflict with the role of the triage system.

The Enhanced Crisis Assessment and Treatment (ECAT) is an emergency-department-based psychiatric assessment and treatment service. Similar to the CAT services, ECAT services have also a gate-keeping function.

Between 2001 and 2006 a significant increase is seen in CAT contacts with aged care assessment services (43%), ambulance services (49%), client groups (33%) and the police (26%). The number of contacts with the family without the presence of the client has decreased (-13%). A very significant increase of CAT contacts with acute health problems (101%) matches with the significant rise in referrals from the acute health services. In order to measure the outcome of the short-term intensive treatment of people with an acute mental illness, the Health of the Nation Outcome Scales (HoNOS) is administered on entry and discharge from the CAT services[236].

2. Continuing care (9)

Primary mental health care in general practice

Primary mental health care and the role of the general practitioner is described above (see Better Access initiative). In 2004-2005, 5.5% of all spending by the Governments to *specialised* mental health services went to GPs[227].

Medicare-subsidised psychiatrist and allied health services

The Medicare Benefits Schedule (MBS) covers different types of ambulatory health services, including psychiatrist services (fee-for-service payment), psychologist services and other allied mental health services (both by rebates by Medicare).

In 2007-2008, an average of 6.3 services per patient was provided for 2.9% of the Australian population. The psychiatrist and allied health services represent a rate of 185.2 services per 1000 population (92.1 for the psychiatrist services, 88.7 for psychologist services and 4.5 other allied mental health services), resulting in 1.4% of all MBS-subsidised services.

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ttttttt http://www.health.vic.gov.au/mentalhealth/cat/review07.pdf

Community mental health care and hospital outpatient services ("full mental health service")

This service includes all forms of direct communication (face-to-face, telephone, video link etc) with or without the presence of the patient in the community setting or hospital-based ambulatory care setting. This type of services is Medicare-funded.

In 2006-2007, service contacts nationally reported corresponded to a rate of 288 per 1000 population. The most common principal diagnoses are schizophrenia (31.8%), depressive episode (11%) and bipolar affective disorders (6.7%)(data derived from the National Community Mental Health Care Database NCMHCD). No country figures are available for number of service users, for the five states/territories reporting such data, the number varied from 1140 to 2170 per 100.000 population (Australian Institute of Health and Welfare, 2009 p32)[226]. Adults (15-64 years) consumed 83% of the care.

Ambulatory-equivalent mental health-related hospitalization ("full mental health service")

In 2006-2007, 36.6% of all mental health-related separations were ambulatory-equivalent mental health-related separations, corresponding to a rate of 5.7 per 1000 population (see paragraph13.3.4.2)

CSTDA-funded community support ("mixed service")

Another type of service, funded by the CSTDA for people with different types of disabilities, includes "community support", in order to assist with non-institutionalised living arrangements (such as specialised therapeutic services, counselling and case management). The rate of CSTDA-funded non-residential service users with a psychiatric disability is nationally 224.7 per 100.000 population, of which 14% uses "community support" (31 per 100.000 population).

Mental health-related Supported Accommodation Assistance Program services ("mixed service")

The Supported Accommodation Assistance Program (SAAP) is set up by the Australian Government (Supported Accommodation Assistance Act 1994) to provide accommodation services and non-accommodation support services (e.g. meals, showers) to people who are homeless of at risk of being homeless (SAAP clients). Mental health issues or psychiatric illness are highly prevalent among SAAP clients.

13.3.4.5 Self-help and non-professional

No specific information on type and/or amount of self-help and non-professional services were found, although in official papers the importance of these services is often stressed.

The National Mental Health report 2007[227] indicates that in 2003, 82% of all professional service organisations had some mechanism in place for consumer advice to or participation in decision making structures.

13.4 FINANCING OF THE MENTAL HEALTH CARE SECTOR

Mental health care in Australia is funded by third party funds (government and private health insurance) and out-of-pocket payments[227]. In 2005 3.9 billion AUD was spent (an increase of 85% since 1993): 6.8% of the total expenditure on health care and 7.3% of government health spending. The growth on expenditure for (specialized) mental health services stayed in line with the growth of the overall health sector. State and territory hospital services (29%), state and territory ambulatory care services (23%) and psychiatric medicines (Australian Government) (17%) count for the largest share of the national mental health expenditure. In 2004-2005, community services (ambulatory services and residential non-hospital services) account for 51% of the expenditure of the states and territories. To fulfil the need for community services, the National Mental Health Strategy 1993-2005 emphasised the role of the non-government organisations (NGOs), equivalent to 6.3% of the state and territory mental health funding in 2005.

The growth of the funding on community services is linked with the savings on the stand alone psychiatric hospitals.

Notwithstanding the national increase in spending on mental health care, differences in expenditure between the states and territories increase, affecting the quality of mental care services in some areas.

Next to the specialist mental care, supportive programs are also financed by the government, a ratio of an additional 3 dollars for assistance programs for every dollar specialised mental health care (equivalent to 4.3 billion AUD in 2005).

The growth of 129% (1993-2005) of number of clinical staff is not sufficient to encounter the high level of need. The national specialised mental health-related workforce has an annual increase of 3.5% between 2002-03 and 2006-07, mainly consisting of an increase in nurses, but also of allied health professionals such as psychologists and social workers, salaried psychiatrists, and additional staffing categories. Notwithstanding this, a shortage in workforce remains one of the main concerns in the 2003-2008 National Mental Health Plan Evaluation (see above)[227].

The private sector of mental health services provided in 2004-2005 for 1720 beds or 22% of the total psychiatric beds and employed 9% of the mental health workforce. By 2006-2007, the number of beds had decreased to 1554 (Australian Institute of Health and Welfare 2009)[226]. The number of private hospitals with a specialised psychiatric unit accounts for 15% of all the private hospitals[227].

Approximately 16% of Australian government mental health expenditure is spend to MBS payments to private psychiatrists. Overall a decrease in activity of the private psychiatrists can be seen[227]. In 2006, there were 3258 psychiatrists in Australia, or 15/100.000 population (Australian Institute of Health and Welfare 2009).

13.5 DISCUSSION AND CONCLUSION

13.5.1 The National Mental Health Strategy and its evaluation

1.

In Australia, health care and disability services are organized and financed in a decentralized way, taking into account the general policy delineated by the federal Government. However, in 1992, all Australian governments quite uniquely agreed to participate in a large reform process to improve cure and care for persons with a mental disorder, thereby overarching local and regional policies and rules. Since then, the National Mental Health Strategy is worked out in National Mental Health Plans, intended as implementation guides to realize the goals put forward for the reform process; agreements are made between all Governments on concomitant financing. Every five years, the NMH Plan is evaluated thoroughly and a new Plan is formulated. It is generally agreed on that the NMH Plans are indispensible to maintain and focus momentum for better mental health care.

Additionally, but always in line with the National Mental Health Strategy, other Plans and frameworks have been launched of which the Council of Australian Governments (COAG) National Action Plan on Mental Health (2006-2011)[231, 232] is the most important; this Plan involves annually additional funds amounting to 17% of the total mental health care budget.

2.

Essential in the NMH Strategy is the Plan evaluation and the open communication around results, by web publication or by publication of reports. To realize these evaluations, necessary data is collected through several databases and made publicly available (e.g. "Mental health services in Australia 2006-07"[226]).

The strength of this data collection is based on three factors. First, on its uniformity throughout the country for health care data as well as for data on disabilities, notwithstanding the organization of Australia in States and Territories. Second, on its extensiveness regarding included topics (e.g. number of persons with mental disorders using employment support services).

Third, on the fact that for ambulatory as well as for residential mental health services outcomes are recorded based on validated outcome scales (e.g. the HoNOS scale) and reported in double by professionals and by service users[uuuuuuuu], which is –to our best knowledge- unique in the world. Still, data collection is under constant revision and adaptation, to further improve it.

The strength of the reports that are published based on this data, lies in the combining of data of different sources: e.g. "Mental health services in Australia 2006-07"[226] combines data on mental health care as well as on disability services (chronic care) for persons with a mental disorder; data from the Commonwealth are included as well as data from States and Territories.

3.

Starting from this impressive data collection, a critical evaluation is disseminated on a regular basis in the National Mental Health Reports[227]. Further, each five years two independent internationally recognized experts on mental health services organization evaluate the changes introduced by the previous NMH Plan. This evaluation is mainly based on site visits and extensive consultation rounds with professionals as well as service users and other stakeholders, specifically enhancing the critical analysis of the situation "on the field". Also other Plans e.g. the COAG Plan[232] 2006-2011 are critically evaluated and the results are made publicly available.

4.

Since the start of the reform process, many positive evolutions have been noticed (see further). Nevertheless, one of the recent criticisms on the NMH Plans has been their vagueness, being exceedingly broad by trying to "be all things to all people"[229]. E.g. one of the aims of 3rd NMH Plan (2003-2008) was to "improve service responsiveness by improving access and continuity of care", without putting priorities or being explicit on the targets that should be reached. In the fourth NMH Plan (2009-2014) [vvvvvvv], general aims are translated into actionable and prioritized items, which are coupled to measurable outcome indicators (some indicators are still under development).

5.

The Fourth and most recent NMH Plan (2009-2013) and the CAOG National Action Plan on Mental Health (2006-2011) deal with topics on the patient level, the service level and the level of the administration (see chapter 4.1.1.6 and 4.1.1.7).

Given the scope of this report, specifically worth mentioning are:

-on the patient level, an emphasis on: sufficient funds for community services to meet needs; housing, employment and vocational support, support for family and carers. It also includes (reimbursed) introduction of care coordinators for severely mentally ill persons.

-on the service level, an emphasis on: coordination between different services, continuity of care, involvement of consumers and carers in service planning and evaluation. It also includes the Better Access initiative, which facilitates treatment or treatment coordination by GPs and other primary care workers, by introducing adapted reimbursement fees.

-on the administration level, an emphasis on: Governments working together, development of a national service planning framework, the use of standards for mental health services, the use of quality and performance indicators, development of a strategy to increase workforce capacity, development of a national mental health research strategy.

[uuuuuuuu] Australian Mental Health Outcomes and Classification Network (AMHOCN), see www. amhocn.org

[vvvvvvv] http://www.health.gov.au/internet/main/publishing.nsf/Content/Mental+Health+and+Wellbeing-1

Although the importance of some of these points is also stressed in other countries that were studied in this report (e.g. continuity of care, care coordination between different services), the authors of this report get the impression that Australia is one step ahead (e.g. the Better Access program (see further), direct reimbursement of a care coordinator for severely mentally ill persons, Governments working together). It also invests in points that are less conventional, but in line with results of the literature review (investment in employment and vocational support). It stresses time and over again the importance of the voice of consumers and carers, tries to find realistic ways to involve them in organizational processes, and monitors the outcome. Finally, it invests a lot in administrative tools such as definition of service standards, quality and performance indicators (some other countries alike); and it also develops a nationally coordinated mental health research strategy.

6.

Nevertheless, the evaluation of the 3rd NMH Plan[229] published in 2009 recognized that while there had been substantial progress since the 1992 National Mental Health Plan, much remained to be done. It listed the initiatives taken in answer to the 2nd NMH Plan, but much of these initiatives had a local and/or temporary basis. It also openly referred to two highly critical documents, one from the Senate Select Committee (2006) and another (2005) from the Mental Health Council of Australia, both highlighting the many problems still existing, especially for persons with a mental disorder living in the community.

13.5.2 Results of the reform process

1.

It has been recognized that major disparities (up to three-fold) still exist between different States and Territories when it comes to certain service delivery practices (e.g. admission); differences between jurisdictions should be interpreted with caution[226, 227]. Also the rate of implementation of the NMH Plans differs between States/territories, sometimes leading to differences in patient accessibility to services such differences are deplored. Given the scope of this report, no further information on data of States/Territories will be included.

2.

Between 1992 and 2005, the total amount of money spent in mental health care remained relatively constant on 6.8% of the total health care expenditure (or 7.3% of health spending of national government and States/Territories together). In other words, the influence of the National Mental Health Strategy did not augment this percentage[227]. Given the ratios of other developed Western countries, this is a rather modest percentage. However, since 2006 a substantial increase of funds has been created under the CAOG National Action Plan. Also, for each AUD spent by the federal Government on mental health care, another 3 AUD is spent to other support services to assist people with mental disorders, e.g. income support, housing services[227]. Comparable numbers for other countries discussed in this report were not found.

3.

Worldwide the mental health care sector is in evolution, characterised by a transfer of beds from specialised psychiatric hospitals to a reduced number of beds in general hospitals and an expanded offer of community care services.

The same de-institutionalization tendency has been noticed in Australia since the 1960s, and it continued under the National Mental Health Strategy. Between 1993 and 2005 the number of beds in stand alone psychiatric hospitals decreased from 73% to 38% of Australia's total psychiatric inpatient capacity[227]. Acute beds were mainly transferred to newly established acute psychiatric beds in general hospitals, implying a relatively constant number of acute beds. However, some scepticism is advised because the increase of non-acute beds in residential community settings only amounted to 25% of the decrease of such beds in the old psychiatric hospitals.

Although it has been recognized that alternative models of accommodation support in the community are being developed, only limited information is available yet on such services, some of the registration systems and databases being only recently created. However, the authors of this report get the impression that in Australia, many persons with a mental disorder receive community support under the CSTDA-funded services, which are mixed services for people with different types of disabilities. This might (in part) replace the decrease of long-term beds.

Also in the other countries studied in this report, scarce information is yet available on community services supposed to replace the decline in stand alone psychiatric hospital. This remains a weak point in the de-institutionalization policy, and implies that vulnerable people discharged from the hospital and living in the community might not have access to the support they need.

4.

Notwithstanding this criticism, between 1993 and 2005, the community expenditure increased from 29% to 51% of the total State and Territory budget, which means that community services are growing[227].

5.

Particular to the organisation of mental health care in Australia, is the prominent role of primary care. The Better Acces program[226, 233] emphasizes the role of the GP in the prevention, early intervention, treatment and referral of a patient with a mental health disorder. The success of the program is mainly due to the linkage with the Medicare Benefits Schedule, resulting in a higher fee for the doctor and a reimbursement for the patient. The role of the GP is not limited to the treatment of the patient but also being the coordinator of the care around the patient. The program was very successful and in 2005, 5.5% of all mental health care expenditures went to GPs[227]. Also for psychiatrists and allied mental health care providers the Better Access program includes specific benefits if they contribute to a better primary care service in mental health care.

14 INTERNATIONAL OVERVIEW: CONCLUSIONS

Although the focus of this report lies on the care organization for persons with severe and persistent mental disorders (SMI), it is often difficult to disentangle this from the general care organization for mental disorders in a certain country. Therefore, many aspects discussed below apply to the general population of mentally disordered persons, and not only the SMI population.

Further, it is important to notice that the results of this international overview, and the conclusions, rely on information from grey sources and information from contacted experts. Inherently to this methodology, a possible bias cannot be excluded. This should be kept well in mind when reading this part of the report.

14.1.1 Deinstitutionalization: where are we now?

Since the 1970s, the mental health care policy in the Western world has been characterized by a strong deinstitutionalisation movement. This movement started as a societal and ethical choice rather than a choice based on scientific evidence, and it emphasized the need to reintegrate mentally disordered persons in the society by downsizing large psychiatric asylums and establishing alternative services in the community. By now, it is generally accepted and also scientifically underpinned (e.g. TAPS project, see KCE report n°84), that this movement had many favourable consequences: for many of the previously institutionalized mentally disordered persons it was possible to stay outside the psychiatric hospital and to keep their community residence, while their quality of life improved greatly. The fact that in the same time period psychiatric medications improved a lot should be stressed as well.

Although many EU countries have seen an important decrease in psychiatric hospital bed numbers since the 1980s, institution-focused services still continue to dominate (Euro observer Autumn 2009)[177]. On the other hand, from the 1990s onwards, there have been concerns whether or not the deinstitutionalization process might have gone too far. Several authors (Becker 2006, Munk-Jorgensen 1999, Fakhoury 2002, Priebe 2003)[68, 237-239] point to the concomitant increase in coercive activities and acute admissions, and even the increasing number of forensic beds. Although a straightforward relationship is not easy to prove, they assume that this might be an expression of a new trend towards re-institutionalization, implying that a certain number of inpatient places will always remain necessary. It is interesting to note that Priebe et al (2008)[220] could not confirm their previous assumption of a direct relationship between decreasing psychiatric inpatient places and increasing forensic beds.

A second issue is the role played by stigmatization. A lack of receptiveness, fear and even hostility in communities towards people with mental illness has been documented several times, e.g. in the UK where murder cases committed by psychiatric patients led to much public commotion. This undermines the possibilities of full reintegration for persons with mental disorders (Becker 2006)[237]. It is important to conduct further research in this domain.

A recent evaluation by Priebe et al (2008)[220], learned that even between 2002 and 2006, deinstitutionalization further continued in several European countries (e.g. Spain, Denmark, England), be it at a slower pace than before and not consistent throughout all countries. Also in Australia, the deinstitutionalization continued during these years (see chapter 13.1.6). Of all countries for which this information is available in this report, Australia succeeded most in transferring hospital beds from psychiatric (47%) to general hospitals (53%); it also has a remarkably low total number of hospital beds. Some criticism exists on the lack of residential non-hospital places, but investment in outpatient and community care is high- although numbers between the countries remain difficult to compare.

In the Netherlands (and in Germany), there was an opposite tendency, namely a slight increase in conventional inpatient beds notwithstanding the fact that in this study these 2 countries had the largest overall number of such places (136 resp. 153/100 000 population in 2006). This confirms the conclusion of the 2008 Dutch Trimbos report[207] (see chapter 9.3.5.3): although there are several explanations for this high number, the Dutch mental health care does not offer enough opportunities to these patients for real integration in the society ("verkokerde zorg"). Meanwhile, several measures have been taken in the Netherlands (see chapter 9).

Belgium

Also in Belgium, there is probably room for some further deinstitutionalization

The Belgian number of conventional inpatient psychiatric beds is high (127 places, see chapter 14.1.6 International Overview). Psychiatric cure (diagnosis and treatment) is still mainly concentrated in « Psychiatric hospitals » (82% of residential places) rather than in psychiatric departments of general hospitals (18% of residential places). For PNH (Psychiatric nursing homes) and ISL (Initiatives of sheltered living), the norms decided on by law are not yet reached, yet there are long waiting lists to enter. Among many others, the relatively high out-of-pocket payment for the patient might be a reason explaining this phenomenon (see KCE report n°84). Although more difficult to point out, the impression exists that the provision of day centers and especially work- and work-related activities (the division "day and structured activity" of the European Service Mapping Schedule (ESMS)) so far is still limited available and that additional initiatives might be necessary as well. The same remark has been made for several European countries, though (Becker 2001)[240].

14.1.2 The balanced care model

Observations of the deinstitutionalization process combined with scientific studies, led to the concept of "balanced care", as already pointed out before (see chapter 5.2.2). This model implies that elements of both hospital and community care are necessary to provide contemporary psychiatric treatment and care. It also implies a "stepped care", including a 1st level (primary care with specialist back-up), a 2nd level (mainstream specialist care: outpatient clinics, community mental health teams, acute in-patient care, long-term community based residential care, services in charge of employment and occupation), and a third level (highly specialized). This 3rd level or highly specialized mental health services are optional, but it is supposed that high resource level countries are able to offer some of them. Some of these specialized services are already implemented in most Western countries, e.g. specialist eating clinics.

In most countries that were studied in this report, the implementation of newer, mostly 3rd level concepts such as ambulatory crisis intervention teams, early psychosis intervention teams, assertive community treatment, remains limited. In most countries the funding of such initiatives relies on temporary or ill-described budgets, and the degree of their implementation has not yet been clearly evaluated. Only in England, it is made one of the performance indicators to organize such teams, and an extra part of the NHS budget has been allocated to reach this target. Exact figures of their implementation are available and updated every 2 years.

In Belgium, the development of such initiatives, although existing, is mostly depending on local initiatives and (temporary) budgets. A few examples are given in chapter 7.4.2.2.

It should be emphasized that some of these initiatives, e.g. outreach crisis teams, have been thoroughly evaluated and appear to be as effective but more appreciated by the mentally disordered person and his/her family (see chapter Literature review). Other, e.g. early psychosis teams, are not been fully scientifically studied yet, so further careful evaluation of their merits and weaknesses is still necessary. It should be repeated once more that care organization always depends on local circumstances, and that the local context should be evaluated before implementing new or additional care forms.

14.1.3 Organization of contemporary mental health care.

During the last decennium, a general tendency in highly developed countries has been to integrate mental health care and other health services, and to integrate mental health services with generic social services. The aim is to struggle stigmatization, and to treat mentally disordered persons like all other citizens. Again, this model has been a societal choice, and its feasibility and/or efficiency has not been proven (yet). **All countries that have been evaluated in this report, currently try to embed the provision of mental health care including the aspects of daily functioning, rehabilitation and social reintegration, in the global system of healthcare and social care of their country. They all struggle to find their way in this complex field, and no model can be said to be the only one or the optimal way.**

In France, Denmark, England, and Australia health care is organized in a decentralized way, and more or less large regions have the principle responsibility for the organization and funding of comprehensive health care in their territory, within the framework of the national legislation. Chronic care and social support are decentralized as well in these countries. In Australia chronic care is the domain of the States and the Territories. In France, Denmark and England organization and funding is separate from health care and mostly confined to (much smaller) local authorities. These local authorities have the responsibility for many other target groups in need of social support and usually don't work with earmarked budgets. This makes it difficult to trace back the spending. In all countries, some overlap exists at the borders between (long lasting) medical care and chronic or social care.

The situation in Spain is comparable: health care and chronic/social care both are confined to the 17 ACs (Autonomous communities), be it under separate organizational and financing structures.

Whereas the decentralized nature of care organization in these countries initially had the purpose to allow care organization depending on the local needs, nowadays the large inequalities between regions as to service provision are deplored, especially in France, Spain and Denmark. In Denmark, a new tendency to some more centralization has been installed recently, including some measures concerning mental health care provision (see chapter 11). England has a long tradition of decentralized care in the community. In their system, special teams are involved to monitor care needs, to supervise implementation of the services needed in their region, and to look for provision of consultancy services if necessary. These LITs (local implementation teams) also play a role in the reporting of actual care provision to the central government. They also seem efficient when it comes to implementation of new types of services. The NHS funding system underpins the central role of these LITs in care organization.

In the Netherlands, organization of health care is organized on a national level, and not decentralized towards specific regions. Chronic or long-term care, i.e. care for illnesses that last more than one year, belongs to the responsibility of another nationally organized system, the AWBZ. The AWBZ largely relies on "functional indications" (e.g. treatment, nursing, accommodation, provision of daytime activities) and "intensity of care" to determine reimbursement level rather than on medical diagnosis, although medical diagnosis still plays a certain role in the final decision on entitlement. An independent agency decides whether one is entitled a certain reimbursement or not. The Dutch system has a third pillar: the social support and welfare (WMO; e.g. support to run the household, support to volunteers, to homeless persons, etc.) confined to the municipalities. The budgets of the WMO are (mostly) not earmarked, and people with all types of handicaps, elderly people as well as people with psychosocial problems belong to their target groups.

Belgium

In Belgium, much of the care organization for mentally disordered persons belongs to the competencies of the federal government. This implies not only acute and/or pure medical care provision, but also several aspects of long-term care such as the organization of PNH (Psychiatric nursing homes), ISL (Initiatives of sheltered living), etc.. This is surprising, since aspects of chronic care for adults, e.g. chronic care for mentally or physically handicapped persons, typically belong to the responsibility of the regional Governments. In Flandres, the VAPH (Vlaams agentschap voor personen met een handicap) is in charge of the practical organization of chronic care, in the Walloon region the AWIPH (Agence wallonne pour l'intégration des personnes handicapés), in the German region the DPB (Dienstelle für Personen mit Behinderung) and additionally in the Brussels region the SBFPH (Service Bruxellois francophone des personnes handicapées). Their offer is very diverse and consists of settings for residential care, semi-residential care, day care, short-term care, respite care, reference centres, services for support at home, sheltered workshops, personal assistance budget… In the domain of mental health care, their main responsibility is the organization of the CMHTs (Community mental health teams).

It is obvious that historical backgrounds can explain the current situation, and the fact that currently many aspects of the cure and care for mentally disordered persons falls under the single responsibility of the federal government, certainly has potential advantages (see further). **However, much of the experience existing in the Belgian regional agencies responsible for long-term care, cannot be directly used for mentally disordered persons.** To make it even more complicated, there are exceptions, such as persons with autism, who do belong to the competencies of the regional agencies.

For some aspects of social support and welfare, the Belgian local authorities are responsible, e.g. financial support for the poor, support in finding a new job after a long-lasting illness. Mentally disordered persons can apply for these services, but like in other countries, no specific information is available on the use of these services by this target group. An exception is Australia, where such numbers are available (see Table in paragraph 14.1.6)

14.1.4 Care organization: integrated care, continuity of care, care programs and networks of care

Last decades, the concepts "integrated care" and "continuity of care" have been used broadly in the field of service organization for people with complex disorders. **These concepts are also widely considered to be important elements of contemporary care for mentally disordered persons, especially for those with severe and persistent mental disorders. They are mentioned in many official governmental documents as major targets to aim at, e.g. in France, the Netherlands, Spain, England, Australia and also Belgium.** Increasing emphasis is also being placed on the implementation of care pathways for mental health (e.g. in the Netherlands) or care networks (France).

In France, the CMHTs (community mental health teams) are mandated to provide care coordination at a patient level, but for many different reasons so far are not successful. Care networks have also been put forward strongly as a means to improve continuity of care at the patient level. However, in 2008 only 32 mental health care networks had been established, most of them situated in 15 of the +-800 regions (Rapport Milon 2009, p 68, see chapter 8)[200]. Continuity of care between clinical and social care is also an important problem. Since 2003, several reports have recommended on improvements of the situation, and extra budgets have been made available. It is unclear how far the recommendations of these reports have been implemented yet.

In Spain integrated care and care continuity between primary care and specialized care have been explicitly put forward as one of the targets of the "Psychiatric reform" in mental health care since the 1980s. The CMCTs are officially in charge of care coordination at the patient level.

However, no specific information on the actual realization of this target could be found. Likewise, no information is available as to the collaboration between health and social care.

In the Netherlands, collaborative practice between mental health care organisations was heavily promoted in the 1990s; even the merging of several mental health care institutions was stimulated. Each region should provide all types of care services, in an integrated way, to make sure that continuity of care could be guaranteed to the patient ("ketenzorg"). The regions succeeded in their mission ("regionalisering"): by 2005, forty large integrated mental health care facilities were responsible for most of the Dutch mental health cure and care supply. According to the Trimbos scientific institute[207], this success might (partly) have been facilitated by the one and uniform funding system (the AWBZ, see chapter 9). Notwithstanding their advantages, the integrated care circuits were criticized for not having developed care integration outside the mental health cure and care sector itself ("verkokering"). Recently the system has been changed again to counterbalance these shortcomings; it is still too early to evaluate these new reforms on their merits and disadvantages.

During the same period, the development of mental health Care programs was stimulated as well to guarantee continuity of care at a patient level; these programs should be as much as possible based on solid scientific evidence. The Trimbos institute estimated in 2007 that 60% of the mental health care services used care programs, and that 850 (regional) care programs were used for 40 different target groups. However, no official documents were found on the quality of these care programs, their outcome, nor on their appreciation by patients and care providers.

In the Netherlands, a consensus has grown that is most practical to distinguish 8 general "mental health Care circuits": children and adolescents, adults, elderly persons, forensic psychiatry, addiction care, long-term care and accommodation, primary mental health care and mental health prevention.

In Denmark, the patient's pathway through the Danish health care system remains hindered by a lack of coordination regarding the primary/secondary care interface, regarding different care providers etc. The Danish Health Care Quality Assessment Program has to pay specific attention to this problem. Joint planning between health care (regions) and long-term care or social care (municipalities) is obligatory by means of the "health agreements" which have to comply with centrally defined requirements; their actual realisations are made publicly available. One of the obligatory agreements includes arrangements on the social services for mentally disordered persons. Regional consultative committees should create a basis for continuous dialogue about planning between health and social care. Although it is admitted that the system certainly has some weaknesses, there have been substantial improvements in terms of formalizing a more coordinated care system.

In England, CMHTs have an important role in care provision and coordination for mentally disordered persons, and the role of GPs has been stressed by the Government as well (1999). The importance of continuity of care between health and social care at the patient level, has been further emphasized by the Care program approach (CPA), introduced by the NHS in 1991 to provide a framework for effective mental health care. A regular assessment of health and social needs, the formation of a care plan and the appointment of a care coordinator belong to its main principles. Since 2008, its use has been confined to persons with more complex mental health care needs. No information on the effect of the CPA on health and quality of life of the persons using this system has been found. Some criticism has been formulated on its rather formal character, while in practice collaboration between health and social care remains difficult (Crawford 2004)[54]. On a service's level, collaboration between health and social care is made possible through NHS Care trusts, which are usually set up when the NHS and a local authority decide to work closely together. These Care trusts should facilitate coordination between health and social care. Also, it is mandatory in England to organize meetings between local healthcare and social care professionals, but the effectiveness of this rule has not been studied.

In Australia, the government took several initiatives. The central role of the GP in mental health care has been emphasized strongly by creating specific reimbursement conditions, allowing GPs to provide first line mental health care including psychotherapy. This should allow better accessibility. At the same time, the GP became the principal coordinator for mental health care; collaborating psychiatrists also get specific reimbursement conditions. The system has been highly successful so far. Additionally, for SMI persons, a reimbursed care coordinator can be engaged, to address coordination problems specifically between health and social care at the patient's level. On the services level, the Australian government went far in stimulating collaboration between health and social care by creating one common Plan, that is evaluated regularly, and for which joint outcome reports are written including data on all aspects of mental health care as well as social care for mentally disordered persons.

In Belgium, the concept of care coordination and integrated care in mental health care has been introduced by the "Therapeutic projects", and recently by the "Experimental projects". Last years, the CMHTs are also stimulated to coordinate care for their clients, but it is not clear how far this has been realized. Consultative committees organized by the Federal government, the "Concertation platforms" exist already longer and should create a basis for continuous dialogue about planning of mental health care. Some regional initiatives are the « Institut Wallon de santé mentale », and recently the Walloon « Centres de référence de santé mental » for coordination of community mental health care centres. Other federal and regional initiatives that are not confined to mental health care exist.

In conclusion, most information on practical implementation of integrated care at the service's level is available for the Netherlands and England, but even in these countries, it is mostly not known what has been their level of implementation, or their effect on and appreciation by mentally disordered persons. The impression exists that the Dutch regional integrated care circuits succeeded most in realizing several elements of what integrated care ideally should realize, but nevertheless, the system has been criticized and subjected to new reforms. Precise descriptions of what exactly made up the active ingredients of these integrated care circuits are difficult to find. According to the Trimbos institute, their success might (partly) have been facilitated by the one and uniform funding system. The Australian government went far in stimulating collaboration between health and social care by creating one common Plan, that is evaluated regularly, and for which joint outcome reports are written; in England care trusts specifically address this type of collaboration.

Care pathways in mental health care have been most implemented in the Netherlands, but precise information on their effectiveness or appreciation by the patients is lacking.

As to care coordination at the patient level, England and Australia point out care coordinators for persons with complex mental disorders or SMI persons; in Australia specific reimbursement is provided. No information on the effect on health and quality of life of the persons using this system has been found. In England, assertive outreach teams also provide care coordination for SMI persons, and CMHTs are assumed to do so for their overall population.

14.1.5 Evaluation of quality of care, Performance indicators

In France, Spain, as well as in Belgium, there is a general accreditation system for hospitals, but the quality assessment system has not been designed as a cost/efficiency measurement framework.

In Denmark, a general Health Care Quality Assessment Program has been established in 2002, which is also applied to mental health care. Standards and measurement indicators are supposed to support internal quality assurance, benchmarking and external accreditation. Quality data are published on the Internet to facilitate comparison and choice. One of the 7 diagnostic areas for which quality as well as patient satisfaction ratings can be on-line compared is schizophrenia.

In the Netherlands, England and Australia, the development of quality and performance comparisons in the domain of mental health care has been initiated. In England, certain indicators e.g. the provision of early intervention teams, already entitle the local team to extra NHS-funding.

In conclusion, it seems to be feasible to evaluate quality of care and care performance in routine mental health care, even for severe and persistent mental illness, but these initiatives are still in the early phase of their development and need further elaboration. Where they do exist, they are part of a larger system of routine quality assessment.

Finally, if one really wants to know whether cure and care provisions are sufficiently available and accessible as well as apt to answer patients' needs, it is necessary to document the available care provision, and to study if patient's needs are met or not. Australia is clearly ahead as to this point: necessary data are collected through several databases (hospital, ambulatory care , welfare,…) and made publicly available. In England, this has been done by organizing a service mapping on a regular basis ((www.mentalhealthobservatory.org.uk). In France a lot of information has been collected in an in-depth study by Coldefy (2007)[187-189]. International scientific studies have been put in place, even including costs (Becker 2002, "Epsilon" study)[216]. Although it is admitted that in particular mapping services and collecting data is a difficult process with many pitfalls such as incomplete data, difficulties to choose appropriate outcome parameters and to determine their cut-offs, possibly different interpretations of the used terminology etc., it is a necessary process to monitor what is going on in reality, and how far the proposed goals are reached (or not).

14.1.6 International overview

The tables below present available data per country, per type of setting according to the ESMS (European Service Mapping Schedule, Johnson 2000).

Belgium, France, the Netherlands, Spain, Denmark, England and Australia are presented successively.

The last table gives a global overview of the most essential data per country.

The purpose is to present a global overview only.

Caution is warranted in the interpretation of this data, since individual data might point to different subpopulations, different reference years, or different ways in collecting data. This has been corrected for as much as possible, but it was not always possible to derive this information from the original data.

For additional information, the reader is referred to the descriptive summary per country.

<table>
<tr><th colspan="6">Belgium: Residential care</th></tr>
<tr><td colspan="6">Places/100.000 population</td></tr>
<tr><td colspan="2">Residential generic acute</td><td colspan="3">Residential non-acute</td><td rowspan="3">Total hospital acute – non-acute</td><td rowspan="3">Total residential non-hospital
Acute/ non-acute</td></tr>
<tr><td rowspan="2">Hospital</td><td rowspan="2">Non-hospital</td><td colspan="2">Hospital</td><td>Non-hospital</td></tr>
<tr><td>Full time</td><td>Part time (night)</td><td>Full time or less than FT support</td></tr>
<tr><td><u>67,5 places</u>
(34% in general hospitals; 66% in psychiatric hospitals)</td><td>NA</td><td><u>59,9 places</u>
(2% in general hospitals; 98% in psychiatric hospitals)</td><td>NA</td><td>Total: <u>76,8 places</u>
- ISL 34,9
- PNH 30,9
- Tf 6,7
- NIHDI conventions 3,5</td><td><u>127,4 places</u> (adults+elderly) of which 82% in psychiatric hospitals; 18% in general hospitals</td><td><u>76,8 places</u> (+ acute)</td></tr>
<tr><td colspan="6">- Psychiatrists: 18/100.000 population (WHO 2005)
- Mental health care spending amounts to 6% of total health care spending (WHO 2005)</td></tr>
<tr><td colspan="3">- Adults (> 18 years, including psycho-geriatric care)
- Reference year: 2007</td><td colspan="3">- Full mental health services
- NA: figures not available
- /100.000 population: general population, not only adults</td></tr>
</table>

<table>
<tr><th colspan="7">Belgium:
Day & structured activities - Outpatient & community care</th></tr>
<tr><td colspan="2">Places or users(yr)/100.000 population</td><td colspan="4">Users/100.000 population/year</td><td rowspan="3">Self-help & non-professional</td></tr>
<tr><td colspan="2">Day & structured activity</td><td colspan="4">Outpatient & community</td></tr>
<tr><td rowspan="2">Acute</td><td rowspan="2">Non-acute</td><td colspan="2">Acute</td><td colspan="3">Continuing care</td></tr>
<tr><td>Mobile</td><td>Non-mobile</td><td>Mobile</td><td>Non-mobile</td><td>Total</td></tr>
<tr><td>NA</td><td><u>Total: 31,6 places or 184,9 users</u>
(Day centers not exhaustive)
- Day hospitals: 22, 7 places or 110 users
(87% psychiatric and 13% general hospitals)
- Day centers:
NIHDI conventions: psychosocial centers 3,6 places or 30,2 users; addiction centers 5,3 places or 44,7users</td><td colspan="2">Overall: NA</td><td colspan="2">Overall:
a) 635 users (1)
- Community mental health teams(2) (CMHT)
b) NA
- Outpatient clinics
- Independently working psychiatrists or psychologists</td><td>See CMHT</td><td>NA</td></tr>
<tr><td colspan="7">(1) of which 573 adults (18-60 yrs)
(2) derived of Flemish CMHTS only</td></tr>
<tr><td colspan="3">- Adults and elderly (> 18 yrs)
- Reference years: 2007, 2009 (see text)</td><td colspan="4">- Full mental health services
- NA: figures not available
- /100.000 population: general population, not only adults</td></tr>
</table>

France: Residential care						
Places/100.000 population						
Residential generic acute		Residential non-acute			Total hospital (acute – non-acute)	Total residential non-hospital (acute–non-acute)
Hospital	Non-hospital	Hospital		Non-hospital		
		Full time	Part-time (night)			
NA[1]	NA (existing in 3% of sectors)	91,4 places 1/3 general and 2/3 psychiatric hospitals/ 76% sectorized [2] and 24% non-sectorized beds/ 96% of all patients or 487 users/100.000 population/yr in need of residential non-acute sectorized services used hospital beds and 4% non-hospital services	3,9 places (9,8 users/100.000 population/year)	19 users/100.000 population/year All sectorized services together; consisting of: - Time-limited: o Centres de post-cure o Appartements thérapeutiques o Appartements associatifs - Indefinite time: o Acceuil familial thérapeutique o Service d'hospitalization à domicile Note: see residential non-acute hospital	95,3 places or 496,8 users/100.000 population /year (sectorized + non-sectorized beds) (1/3 general and 2/3 psychiatric hospitals)	19 users/100.000 population/year [3] (sectorized data only)

(1) in the consulted database (Coldefy 2007)[187-189], all hospital beds are classified as 'non-acute'. However, many hospitals (generic or psychiatric) are involved in emergency care

(2) sectorized beds: beds organized within the official psychiatric geographical sectorization policy. The largest part of non-sectorized beds is not publicly funded (private).

(3) With much caution extrapolated to 3,7 places 100.000 population/year

- N° of psychiatrists: 23/100.000 population (2004)
- Mental health care expenditure is 10,6% of total health care spending (2005)

- Adults - Reference year: 2003 or 2004	- Full mental health services - NA: figures not available - / 100.000 population: general population, not only adults

France: Day & structured activities - Outpatient & community care									
Users/100.000 population/year									Self-help & non-professionals
Day & structured activity				Outpatient & community					
Acute	Non-acute			Acute		Continuing care			
	High intensity	Low intensity	Total	Mobile	Non-mobile	Mobile	Non-mobile	Total	
NA	84 users (sect + non-sect) - Day hospitals	142,9 users (sect. only) - Centres d'accueil thérapeutiques à temps partiel (CATTP) - Ateliers thérapeutiques - autres	226,9 users	NA	NA (mainly CMP)	297 users (sect. only) - CMP (Equipes psy-précarité : NA)	1298 users (sect. only) - CMP (outpatient clinics, private psychiatrists, psychologists, psychoanalists : NA)	1595 users	User associations involved in 16% of sectors ; families involved in 23%

- Adults
- Reference year: 2003
- Sect + non-sect: sectorized and non-sectorized psychiatry (see text)
- Sect only: sectorized psychiatry only
- CMP: centres médico-psychologiques (CMHT)

- Full mental health services
- NA: figures not available
- / 100.000 population: general population, not only adults

The Netherlands: Residential care						
Places/100.000 population						
Residential generic acute		Residential non-acute			Total hospital (acute – non-acute)	Total residential non-hospital (acute – non-acute)
Hospital	Non-hospital	Hospital		Non-hospital		
		Full time hospital	Part time hospital	Full + part time support		
NA [1]	NA	NA [1]	Night hospital: NA	64 places (74 users/100.000 populations/year)	137 places (general population)	64 places (74 users/100.000 population/year)
- N° of psychiatrists: 15,5/100.000 population - Mental health care expenditure is 6,1 % total health care spending (2007)						
[1]In the consulted reference (Trimbos Trendrapportage 2008)[207], no distinction is made between 'acute' and 'non-acute' hospital beds; no separate data on psychiatric departments of general hospitals, integrated mental health care facilities and psychiatric hospitals are available						
- Figures per adult population (> 18 yrs) unless* or otherwise indicated - Adults and elderly (>=18 yrs), except * (adults 20-65 yrs) - Reference years: 2003, 2004, 2006, 2007 (see text)				- Full mental health services, which in the Netherlands used to be integrated mental health care facilities - NA: figures not available - /100.000 population: general population, not only adults		

The Netherlands: Day & structured activities - Outpatient & community						
Places/100.000 population			Users/100.000 population/year			Self help & non-professional
Day & structure				Outpatient & community		
Acute	Non-acute			Acute	Continuing care	
	High intensity	Low intensity	Total			
NA	32 places/100.000 population - Day hospital	NA - Day centers - Vocational rehabilitation centers - other	230 users*/100.000 population	All categories: 5427 or 4100* users/100.000 population/year - RIAGG - Outpatient clinics (private psychiatrists, psychologists: NA)		NA
- RIAGG: community mental health team (belonging to large integrated care institution or not) - *adults 20/64 years				- Full mental health services, which in the Netherlands used to be integrated mental health care facilities - NA: figures not available - /100.000 population: general population, not only adults		

Spain: Residential care								
Places/100.000 population							Total hospital acute–non-acute	Total residential non hospital acute–non-acute
Residential								
Generic acute		Non-acute						
Hospital	Non-hospital	Hospital		Non-hospital				
		Fulltime	Night hospital					
9,9**places	NA	7,8**places	NA	total 27,8*places			17,7 places	27,8 places
				24h support time-lim. 5,2 places	24h support indefinite 19,6 places	Non 24h support 3 places		
- N° of psychiatrists: 3,6/100.000 population (2005) - Mental health care expenditure is 5% of total health care spending								
- *:adults only (18-65 yrs) - **: adults & elderly (>=18 yrs) (psychiatric & psycho-geriatric hospitals) - *: psychiatric services in general hospitals - Reference years: 2005-2007 (see text)				- Full mental health services - NA: figures not available - /100.000 population: general population, not only adults				

Spain: Day & structured activities - Outpatient & community care						
Users/day/100.000 population	Users/month/100.000 population					Self-help
Day & structured* activity			Outpatient & community services*			
Acute	Non-acute	Total	Acute	Continuing care	total	
3,2 to 4,8 users	11,7 to 19,3 users (extrapolated to average of 186 users/year/100.000 population) - Day hospitals - Day centers - Most services no work-related activities	NA	16 to 67 users (extrapolated to average of 498 users/year/100.000 population) - Non-mobile services - Mobile services rare (e.g. Madrid)	607 to 1675 users (extrapolated to average of 13.692 users/year/100.000 population) - Mental health centers - Outpatient clinics - Mobile services rare (e.g. Barcelona) (Independent psychiatrists: NA)	Extrapolated average of 14.190 users/year/100.000 population)	NA
*: adults only (18-65 years) - Reference year: 2005 (see text)			- Full mental health services - NA: figures not available -/100.000 population: general population, not only adults			

Denmark: see overview Table

England: see overview Table

<table>
<tr><th colspan="8">Australia: Full mental health services - Residential care</th></tr>
<tr><td>Places/100.000 population</td><td>Users/100.000 population/year</td><td colspan="6">Places/100.000 population</td></tr>
<tr><td colspan="2">Residential generic acute</td><td colspan="4">Residential non-acute</td><td rowspan="3">Total Hospital acute – non-acute</td><td rowspan="3">Total Residential non-hospital acute – non-acute</td></tr>
<tr><td rowspan="2">Hospital</td><td rowspan="2">Non-hospital</td><td colspan="2">Hospital</td><td colspan="2">Non-hospital</td></tr>
<tr><td>Full-time</td><td>Part-time (night)</td><td>Full time support</td><td>Less than FT support</td></tr>
<tr><td>Public: 14,6 places
Private: NA</td><td>NA</td><td>Public: 5,8 places
Private: NA</td><td>NA</td><td>3 places</td><td>19,1 places</td><td>Public: 20,4 places
Private: 4,9 places
Total: 25,3 places (adults)
Total (all populations): 36 places* of which 53% in general hospitals and 47% in psychiatric hospitals</td><td>Total 22,1 places (adults) (+ acute)
Total 25,4 places (all populations) (+ acute)</td></tr>
<tr><td colspan="8">- Psychiatrists: 3258 (in 20006) (Health & W 2009 p.144) → 15/100.000 pop
- Mental health care spending amounts to 6,8% of total and 7,3% of government health care spending</td></tr>
<tr><td colspan="4">- *: WHO Mental Health Atlas 2005: 39/100.000 population
- Adults (18-65 yrs), unless otherwise indicated (see ‘Total’)
- Reference year: 2005, 2006, 2007 (see text)</td><td colspan="4">- Full mental health services
- NA: figures not available
- /100.000 population: general population, not only adults</td></tr>
</table>

Australia: Full mental health services – Day & structured activities - Outpatient & community							
		Users/100.000 population/year					Self-help & non professional
Day & structured activity		Outpatient & community					
Acute	Non-acute	Acute		Continuing care			
		Mobile	Non-mobile	Mobile	Non mobile	Total	
NA	NA	Overall: NA		Overall: a) 1140 to 2170 users (1) - Community mental health centers - Outpatient clinics b) 3000 users - Medicare subsidized psychiatrist (50%) or psychologist (50%) care (2) c) 570 users - Ambulatory equivalent hospitalization (see text)	N 5795 users	82% of professional service organizations involve consumers in decision making structures
(1) Of which 83% adults (15-65 yrs) (2) GPs provide a significant amount of ambulatory mental health services (see text); however, they are not included here							
- Overall population (not only adults) - Reference year: 2006-2007				- Full mental health services - NA: figures not available - /100.000 population: general population, not only adults			

Australia: Mixed services								
Users/100.000 population/year								
Residential generic acute		Residential non-acute		Day & structured activities			Outpatient & community	
/	Non-hospital	/	Non-hospital		Non acute			
			Full time support	Less than FT support	Acute	Day activity	Employment support	Acute	Continuing care
	NA		1,2 users - institutions - group-homes	45 users - ambulatory accommodation support mainly	NA	69 users	119 users	NA	31 users - community support (counseling, case management)
Mixed services: available for persons with different types of disabilities These data are not available for the other countries studied in this report								
- Adults (CSTDA clients, age at onset should be < 65 yrs)								

International overview: Full mental health services							
	Belgium	**France**	**The Netherlands[1]**	**Denmark**	**Spain**	**England (UK) [4]**	**Australia**
Total hospital places (acute – non-acute)/ 100.000 population	127,4**	95,3	137*	75,8*	17,7	58	25,3
of which % in general versus in psychiatric hospitals	18% general – 82% psychiatric	1/3 general – 2/3 psychiatric	NA	NA	NA	25% general-70% psychiatric-5%community	53% general – 47% psychiatric
Total residential non-hospital places / 100.000 population (acute – non-acute)	76,8	~3,7 (extrapo-lated)	64*	86,9[2]	27,8	24,3	22,1
Residential care: - Adults only, except * and ** - *general population/**adults& psycho-geriatric care - [1] due to the specific organization of the Netherlands, data include all services (full mental health or mixed) used by mental health care patients - [2] ref: Priebe (2008)[220]				- Reference years: 2001 to 2007 - For details, see overview per country - NA: figures not available - / 100.000 population: general population, not only adults - [4] ref: WHO mental health atlas 2005; Priebe (2008)[220]			
Day- and structured activities, non-acute (users/year/100.000 population) (day hospitals, day centers, employment support)	184,9	227	230	NA	186	NA	NA[2]
Out-patient & community acute care (users/year/100.000 population)	NA	NA	NA	NA	498	NA	NA
Out-patient & community continuing care (users/year/100.000 population)	635 – CMHC only	1595 – CMHC only	5427 – CMHC – Outpatient clinics	NA	13.692 – CMHC – Outpatient clinics	NA	5795* – CMHC – Outpatient clinics – Psychiatrist & psychologist
Day & structured activities – Outpatient & community care: [2]Data are available for 'mixed services': 69 users of day centers and 119 users of employment support/100.000 population with primary psychiatric diagnosis; no data for mixed services are available for other countries; they are included in "full mental health services" for the Netherlands							

- Adults only except *
- *general population
- Reference years: 2003 to 2009 (see overview per country)
- CMHC: community mental health center

Involvement of consumer organizations in decision making structures of service organizations	NA	16 to 23%	NA	NA	NA	NA	82%
N° psychiatrists/100.000 population	18	23	15,5	21,8	3,6	11	15
Mental health care expenditure as % of total health care spending	6%	10,6%(3)	6,1%	NA	5%	10%	~7%
(3)According to Coldefy 2007[187-189]. WHO Mental health atlas 2005:8%							

14.2 OVERALL CONCLUSION KEY POINTS

- **The desired outcomes of current mental health care are to attain for each person with mental health problems a maximum level of social participation, employment, self-care, interpersonal relationships, and community participation**

The deinstitutionalisation movement is a normative movement, in which societal values prevail in the organisation and provision of care: needs-based, patient centred, de-stigmatising, close to the patent living area, accessible services aiming at social inclusion and participation. The health care reforms are based on an empowerment model of recovery by people with psychiatric disabilities. These core values have a major impact on how services are to be organised, as can be observed from the international choices (or at least policy discourses) on the organisation of mental health care. However, research is demonstrating that implementing these core values is not a straightforward process, requiring a consideration of a complex set of issues. With regard to the integration of the family in the care process, the issue of burden of care for informal carers is mentioned as particular topic to be discussed.

It is now generally accepted that one should strive for a balanced care approach.

- **Developing evidence on mental health care reforms is methodologically complex. It cannot be reduced to the simple application of evidence rules, as on deals with what is known as complex interventions**

Re-organising mental health services falls under the category of complex interventions. The evaluation and development of evidence and knowledge on complex interventions requires more complex methodological evaluation approaches than what is currently available. The currently available knowledge and evidence does not offer clear-cut answers on organisation issues in mental health care organisation More multi-disciplinary collaboration and a better organisation evaluation research agenda is certainly needed on an international level. More-over one needs to take into account local contexts such as the epidemiological, economic, legal, political, cultural, social, financial, economic conditions as well as the available infrastructures and health services.

- **The international comparison learns that, values closely connected with deinstitutionalisation prevail in the organisation of mental health care, countries make different choices in organising mental health services**

Countries differ widely in terms of geographical extension, population, political, administrative and economic structures, organization and principles of the health and welfare regimes, as well as differences in the health care framework, mental health care organization and many other characteristics. An interesting observation is that the majority of mental health care reforms are regional in character and ended in regional disparities within countries.

In all countries in-patient care is mainly provided in psychiatric hospitals and general hospital psychiatric units. Community mental health centers are found in all countries Some countries have experiences with initiatives of psychiatric hospital closure and many countries took initiatives to avoid long term residential care as much as possible. New forms of long-term residential care are developed and includes nursing homes, supported housing, day care centers etc, to complement and substitute part of the role of long term psychiatric hospitals.

A common trend is the search for developing collaborative models in which both individual providers and different services collaborate or cooperate to provide care. The development of this collaboration requires some reform time and integration of psychiatric care with primary care and other services is a difficult process, internationally. Mental health care reforms require clear policy plans, common understandings and meanings of the objectives of the reforms and well developed reform strategies to maintain the reform momentum over long periods of time.

- **Mental health care reforms focus on community-level models of care that coordinate the multiple health and human service providers in mental health treatment, care and delivery of services**

International reforms and the scientific debate incorporates actions along the closure or reforms of the old mental hospitals, the development of community, and especially efforts to integrate psychiatric and mental health care services with general health services and other social services. However, at this stage there is no clear evidence to what extent these effort to integrate services allow for more effective or efficient provision of care. Research is available though on the problems of non integrated or coordinated provision of care.

- **Mental health care reforms require actions on different levels. The debate on mental health care reforms needs the use of clear meanings of concepts and words, as different levels are often used interchangeably.**

With regard to the evidence debate as well when developing policy programmes, a clear analytical distinction has to be made between the treatment intervention level and care approaches or care methods level (patient level), and the organisational configuration level (service level). Clear communication should avoid misunderstandings, and is an indispensible step towards a well-functioning, more integrated service model.

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