

The Process of Change in European Mental Health Services: The Contribution of Education and Training

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Reform of mental health services has been happening all over Europe, but to varying degrees, and with greatly varied outcomes. The overall thrust of reform has been from a mental hospital dominated system, to one based within and supported by the community. In a useful overview Becker & Vazquez-Barquero(2001) summarise some of the major similarities and differences in European mental health care reform. There were major differences in professional and resource allocation. For example the average provision of psychiatrists ranged from five per 100,000 (England and Wales) to 20 per 100,000 (France). Resource allocation varied from five per cent to 10 per cent of all health care funding. Table 1 illustrates the relative rates of progress as assessed by the authors in community-based mental health care.

Table 1

Country	Acute In-patient Beds per 100,000 population	Progress in health and social care integration
England & Wales	33	Substantial
Netherlands	50	Slow
Sweden	85	Slow
Poland	57	Some
Italy	17	Substantial
France	165	Slow
Spain	50	Slow
Germany	60	Slow
Russia	125	Little

Italy has dramatically the lowest ratio of in-patient beds at 17 per 100, 000, followed by England and Wales at 33 per 100, 000, whereas France still totals a surprising 165 per

100,000. The nine countries in the review were also assessed as to progress being made with respect to the development of integrated community mental health care.

The authors rated progress as “substantial” in Italy – but also (surprisingly) in England and Wales, while progress was rated lower in all the other countries in the survey. Italian mental health services have gained a world-wide reputation for their visionary approach to community-based mental health care. However it is arguable that ‘de-institutionalisation’ has proceeded further and faster in Italy than anywhere else in Europe. This process started in 1978, when the Italian parliament passed the innovative and groundbreaking Law 180, which “decreed the shift from segregation and control in the asylum, to treatment and rehabilitation in the context of society.” (Birti, 2001) The 1978 reform mandated:

- Prohibition of new admissions to the large state mental hospitals
- Implementation of a comprehensive range of community-based services
- Allowance of voluntary and involuntary admission only in emergency situations and only after community alternatives had been tried
- Hospitalisation only in small units (15 beds maximum) located in general hospitals

These 1978 reforms were expanded and enhanced in 1994, by the parliamentary passage of a National Mental Health Plan (Birti 2001). This integrated *all* local catchment area mental health and human resource services under one single administrative umbrella, the Department of Mental Health, typically organised around a population of 150,000, which was tasked to provide the following services:

- Community mental health centre, offering out-patient care and emergency intervention; counselling and support to families; case management; welfare benefit support and advocacy; occupational rehabilitation; job finding; hospital gate-keeping; resettlement of discharged mental patients
- General hospital psychiatric wards (one bed per 10,000 population)
- Day hospitals and day centres (one place per 10,000 population)
- Group homes and other residential facilities with varying degrees of support (one place per 10,000 population)

In 1996 a fiscal law was passed mandating the closure of all state mental hospitals and between 1996-1998, twenty six of them had been closed. In 1998 the National Mental Health Plan for 1998-2000 was published, which further enhanced and moved forward integration to include universities, local administration, voluntary agencies, and full participation of user and carer organisations.

If Italy represents the ‘European maximum’ with respect to a definitive shift towards a genuinely community-based approach to care of the mentally ill, it has to be recognised that for most of the rest of Europe, there is still a long road to travel. The difficulty of achieving definitive shifts towards integrated community mental health services is shown in Sweden where the last 15 years have seen Swedish social services taking a lead role in the integration of community mental health services. The placement of psychiatric care in one sector with one organisation responsible for all care, both in-patient and outpatient, within its own catchment area, was established in Sweden between 1975-1985. However, an evaluation of this reform revealed deep problems in the integration of health and social care (Stefansson et al, 1990): needs for medical treatment was largely satisfied, but social care needs were almost entirely unmet.

In Eastern Europe and the former Soviet Union, resource constraints are perhaps the single most limiting factor. In Lithuania for example, 1.75% of the national budget is spent on institutional care provision. The scale of the challenge, in Eastern Europe in particular, is massive. In this region, some 1.3 million children, elderly clients and adults with disability live in an estimated 7,500 different institutions (Tobis 2000). The difficulty is that institutional care services cannot simply be ignored whilst community alternatives are built up. There is a period of time where there is a ‘doubling of costs’, while the expensive institutional services are still maintained as community alternatives are simultaneously built up– these are not necessarily any cheaper. Many Eastern European economies have in any case declined since 1989. As an example, Eastern European and former Soviet Union economies declined 32 places in the human development index from 1990-1994 (Tobis 2000).

The Contribution of Education and Training

Does education and training have a role in facilitating shifts towards more community-based approaches to mental health services? Clearly it does, although as the Italian example demonstrates, political will and commitment, legislation, and sufficient resources are more important determinant factors. Indeed, it is probably the case that education and training can only be effective in the context of a declared national or at least local policy which highlights a commitment to shift financial and human resources into new community-based ways of working. Education and training are best seen as critical ingredients, but not the only factors in a holistic approach to system change. In order to be effective in facilitating the transition from Hospital to Community Based Care, the following components are needed:-

- Decisive and clear national, regional and/or local policy commitment
- Commitment by decision-makers and resource allocators to redistribute financial and human resources in accordance with declared policy

- Participative inclusive approach to organisational and system change involving all key stakeholder groups
- Commitment from all key professional groups (e.g. Psychiatrists) to reconsider their roles and job descriptions in the light of new policy direction
- Development and evaluation of model community-based services illustrating the new policy shift
- Creation of a locality-based, multi-disciplinary approach to whole-team training, practice development and implementation
- Comprehensive work-force planning and development in order to ensure the requisite distribution in the work-force of the appropriate numbers and kinds of skill-mix and staff
- The design and development of new roles and staffing patterns needed to deliver the new models of care
- Planned and systematic change management which implements successful pilots on an institution-wide, locality-wide, regional or national basis

The clear implication of this analysis is that ‘whole system change’ is necessary. A complex matrix of factors need to be in place in order for decisive shifts towards community-based care to occur. The problem of course is that both regionally and nationally, for many countries it is very difficult if not impossible for all these factors to be present. To take an obvious example - in many countries professional groups including psychiatrists are highly resistant to changing their roles and skill-mix. Without the key professional groups themselves committing to the new policy direction, the necessary institutional and organisational change will be resisted rather than facilitated.

Given this caveat, the model summarised above would argue for the following process. A *‘vision of change’ would through extensive stakeholder consultation be negotiated and agreed*, ideally nationally, but depending on circumstances, regionally or locally. The *key decision-makers, resource allocators and professional groups would ‘sign up’ to and commit to implementation of the agreed policy shift*. A model service embodying the *‘new vision’ would be designed, implemented and evaluated*. On the basis of the evaluation, *design faults would be analysed, identified and corrected*. Through this process, a *‘model service’ could be developed* with realistic chances of effective delivery. Once this stage is reached, *workforce planning and development* would need to come into play in order to assess the overall workforce plans and priorities needed in order to implement the new vision of care.

It is at this point that education and training could make a strategic impact in terms of training the required workforce into the new patterns of skills needed to deliver the new service vision. In order to do this, the education and training function itself needs to be

redesigned and reshaped. Essentially, what is needed in this new approach to education and training is not the training of individuals in the classroom, but rather the *training of whole teams in the workplace*.

Capability Development Centres

A practical example of this new approach to education and training is currently underway in North London, where Middlesex University has negotiated three year funding for a new initiative called Capability Development Centres (Strategic Changes in Educational Delivery: Towards Capability Development Centres (2002). These Capability Development Centres will function as 'day clinics' and resource centres, based as near to hospital and community services as possible. They will have access to meeting rooms, computer terminals, and wide band cable facility in order to allow for video cam conferencing, and video replay skill development. They will be staffed both by senior clinicians with relevant specific expertise and also by University training staff. The task of these Capability Development Centres will lie within the service development strategy established by the clinical services. These are:-

- To facilitate and evaluate the clinical performance of the fieldwork staff in receipt of training by the use of outcome measures linked to clinical governance systems, and the provision of guidance\supervision to further enhance skills development
- To facilitate whole team development in the delivery of effective clinical skills
 - To jointly analyse blocks and inhibitors to effective clinical practice brought about by problematic or dysfunctional elements of organisational structures and service systems
 - To collaborate and advise in the assessment of workforce training needs in accordance with overall strategic service development plans
 - To advise on the contracting and purchasing of appropriately targeted education and training based on specified training analysis

Conclusions

Achieving strategic change in the direction of mental health services towards genuinely community-based approaches is an objective embraced by most if not all European mental health services. It has been an ongoing process and struggle in most countries for the best part of thirty or forty years. There are wide variations both in the kind and degree of success achieved. If any country's services can be said to have successfully achieved

such a transition, then Italy still remains the benchmark. For many countries, progress has been relatively slow and partial.

The reasons for this are not hard to find. Such changes are in the first place expensive to resource, and run up against numerous institutional and professional resistances. Each country necessarily has to find its own solution to these issues based on its own cultural and professional traditions, its own policy-making procedures, and within the overall resourcing and priority given to mental health in the national scheme of things. It is however now possible to identify the complex matrix of factors, which need to be in place in order for effective change to occur, and countries can learn from each other in terms of approaches which appear to be successful. ENTER Mental Health is in an excellent position to identify successful strategies and to facilitate appropriate exchange.

References

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