Mental Health in the City

Conference papers presented by speakers from 10 cities

27–29 October 1997

King's Fund

750 YEARS OF HEALTH IN MIND

Bethlem Royal Hospital 1247-1997

CONTENTS PAGE

CHAPTER 1

MENTAL HEALTH IN AMSTERDAM

A.H. Schene[1], E. Hoffmann A. Goethals

(1) Professor of Community Mental Health Care

Prof. dr A.H. Schene
Academic Medical Centre, University of Amsterdam
P.O. Box 22700
1100 DE Amsterdam
The Netherlands

CONTENTS

1. THE CITY OF AMSTERDAM

1.1 Introduction

In this chapter we describe mental health services in the city of Amsterdam. First general information about Amsterdam's history, the population and housing, the economy and culture and the administration will be given. Secondly, some of the major social and health problems will be described. The third theme is the history of the mental health services in Amsterdam and the development and characteristics of what is called The Amsterdam Model. After some facts and figures about these services have been described, the chapter is closed with the discussion of current issues and conclusions.

1.2 Short history

Amsterdam has been the capital of The Netherlands since 1806, when under French rule this country became a monarchy. Although the Houses of Parliament are located in The Hague, Amsterdam has been the leading Dutch metropolis since the sixteenth and seventeenth century (City of Amsterdam, 1996).

The French period has been hard for Amsterdam. The economic revival did not start until 1870, when investments in the colonies in the Dutch East Indies gave the city the opportunity to become a centre for colonial trade. To become such a centre good transport facilities were important. In 1876 the 30 kilometer long North Sea Channel was opened which gave the harbour of Amsterdam a direct connection to the North Sea. Another important transport facility was the Central Railway Station built in 1889.

At the end of the last century the city quickly expanded into an important industrial centre with shipyards, machine factories, and garment and foodstuff plants. After the Second World War much of the industrial activities disappeared and today the city is mainly a centre for business and financial services as well as for computer and medical technology.

Up until the 1930s Amsterdam expanded in circles around the old inner city with its canals. In 1935 the city council formulated a new conception of city planning. The further expansion of the city was to be in the shape of loops. For the main part this general expansion plan was implemented after the second World War. In the fifties new suburbs were successively added to the outskirts of Amsterdam, to the West, the South and the North.

Despite these expansions the housing shortage remained and in the early seventies Amsterdam added one more large area, the Bijlmermeer, on the south-east side of the inner city area. During the last decades people, mostly families with children, have moved out to new towns, most some ten to thirty kilometers from the city. They were replaced by youngsters, coming to the city to find a job or to go to one of the universities or colleges.

During the last ten to fifteen years a lot of the city's housing has been renovated. Another policy has been to bring living back into the city. Wherever land became available, residential premises were build, especially for single people and couples without children. At the moment new plans are on the way for the construction of an entire new neighbourhood on a number of artificial islands close to the inner city.

1.3 Population and housing

In 1996 Amsterdam had a population of 722,350 including a figure of 316,228 (43.7%) single people. Of all inhabitants 19.9% are younger than 20 years and 13% are older than 65 years, while 6.3% are older than 75 years.

Amsterdam, like most large cities, has a multi-ethnic population. Of all inhabitants 57.6% are Dutch. Ethnic groups are mainly people from Surinam (9.7%), Morocco (6.7%), Turkey (4.3%), Southern-Europe (2.3%) and Antilles/Aruba (1.5%). Of the 17.8% left, 8.3% are from non-industrialised countries and 9.7% from industrialised countries.

The size of the city is 21,242 hectares. The number of housing units is 357,641, including 40,858 (11.4%) privately owned units, 117,977 (32.9%) privately rented and 195,545 (54.6%) rent-controlled units.

In 1950 there were 835,834 people living in Amsterdam, while there were 221,606 apartments available. Around 1960 Amsterdam reached the highest number of inhabitants, 870,000. Since then this number has declined, although new suburbs were added. The number dropped further to the 722,350 people mentioned, while the number of apartments rose to the 357,641 mentioned. Thus the average number of tenants per apartment in Amsterdam has fallen from 3.77 in 1950 to 2.04 in 1996. In 1997 about 47,500 registered people are looking for a place to live; 71% are looking for a two-room apartment. There is an especially great demand for small and inexpensive apartments.

1.4 Economy and culture

The total number of persons employed is 330,964. The employment "top-10" includes commercial services and computer technology (41,192 employees), public health care and welfare (41,065), banks and insurance companies (28,580), wholesale and distributive trade (26,350), retail trade (25,780), government (25,453), school system (21,697), transport and services (16,492), hotels, restaurants and cafes (14,892) and professional organisations, culture and sports (13,008).

In 1996 some 83,000 people (11.5% of the population) were registered as unemployed; 67% of them have been unemployed for more than one year, 37% for even more than three years. Unemployment rates are unevenly distributed over different categories of people. For Dutch natives this percentage is 17, for immigrants from Southern-Europe 20%, for people from Surinam, the Antilles and Morocco it is about 40%, while for the people from Turkey it goes up to 50%.

Most of the unemployed people do not meet the requirements for the jobs becoming available. Two projects, the Work Plan of Action and the Economic Structure Action

Programme try to help the groups of people who do not qualify for regular jobs to find some kind of work. In this way 10,000 employment openings were created in 1996. Another major problem is the 30% of the city's youngsters who leave secondary school without a diploma.

With such a high unemployment rate it will be clear that for users of mental health services the labour market is very difficult to enter. The number of job opportunities that can be used by persons with some psychiatric disability is very low and has decreased over the past decade.

Amsterdam has two universities (35,600 students) and some colleges (28,200 students). It is one of Europe's leading tourist magnets and it has assimilated large numbers of newcomers from other cultures. The national airport Schiphol is located near Amsterdam and is one of the leading European airports. There is a stock exchange and options exchange and most banks have their headquarters in this city. The harbour is, after the one of Rotterdam, the second Dutch port, and the city is the most important cultural centre in The Netherlands.

1.5 Administration

The City Council is the highest authority in Amsterdam and has 45 members. In 1990 Amsterdam completed the reorganisation of its administration. In addition to the central administration, and based on the principle of decentralisation, the city is now divided into sixteen districts of around 45,000 inhabitants on average. They have their own tasks, budget, officials and elected authorities. Like the City Council, the Sub-City Councils appoint their own District Chairman and District Aldermen. The Sub-City Councils are responsible for housing, roads, public parks and lawns, indoor and outdoor public premises, education, public health and the social and cultural facilities in their district.

1.6 City problems

Like every big city Amsterdam has its own characteristics and problems. We have already mentioned the high rate of unemployment. In comparison with The Netherlands the percentage of elderly people (over age 65) is higher, which also holds for the percentage of those living alone, not born in The Netherlands and for people with low education. About one third of the population is on some form of benefit. Unemployment rates are especially high among ethnic minorities and young people, the so-called second generation of immigrants. A lot of these youngsters have a low level of education, and criminality among them is relatively high.

An epidemiological study (Reijneveld, 1994) on the health of the people living in Amsterdam showed that in comparison with The Netherlands as a whole the total mortality, the perinatal mortality, the number of infectious diseases, the percentage unable to work, the percentage with chronic disabilities, the number of suicide attempts and the percentage of hard drug addicts are significantly higher.

One infectious disease, AIDS, has received a lot of special attention during the past decade. By April 1995 a total of 3,488 of the 15 million people in The Netherlands were diagnosed as having this illness. About half of them were living in Amsterdam.

Mobility among Amsterdam people is high. Many people in the beginning of their professional career leave Amsterdam. Because of the high mobility, the high percentages of single people, the increasing individualisation and loss of social networks, the problem of isolation and loneliness has increased considerably.

The differences among the 16 districts are great, not only in terms of population and socio-economics, but also with regard to health and mortality. Amsterdam not only has a higher percentage of young people, but also of old people; not only of rich but also of poor people. The differences between groups are bigger then elsewhere in The Netherlands and they have been increasing over the last ten years.

Another way to look at social problems is to consider the priorities of the police. Criminality and safety in public life are high on the political agenda. The police, in addition to their everyday work, mainly focus on combating juvenile crime, punishable acts affecting public safety, burglaries in homes, organised crime, the local trade in drugs (with priority for the nuisance caused by drug-related forms of crime and the international drug trade), offences against the environment, and traffic safety to reduce the number of traffic victims.

1.7 Ethnic Minorities

At the moment a quarter of the Amsterdam population belongs to one of the five minority groups mentioned, and this figure is expected to rise to one third by the year 2000. Almost half the pupils at the city's primary schools are now of non-Dutch descent and in some districts this percentage is significantly higher. In five to ten years 50% of the youngsters leaving school will be of 'foreign' descent.

In the early eighties it was realised that the majority of the migrants were here to stay in the Netherlands, and so gradually a policy to help immigrants to assimilate was developed. This policy is strongly focused on the youth of today. The school system is still inadequately equipped for the multicultural school population. Special attention is now devoted to elevating the disadvantages certain groups are still facing. The main policy is to bring about a coherent policy to abolish or reduce the educational handicaps of certain pupils, due to social, economic or cultural factors. Special language programmes were developed and parent participation is considered to be extremely important.

1.8 Drug Problems

Leaving out alcohol, we will concentrate on soft and hard drugs. There are about 6000 people in Amsterdam who use heroin and/or cocaine, 1500 of whom are of Dutch descent

and 1,500 from Surinam, the Antilles and Morocco. About 3,000 are from other countries in Europe, mainly Germany, Italy and Great Britain. The average age of the addicts rose from 26.8 in 1981 to 36.2 in 1995. Of these 6000, about 1000 users regularly disturb the peace in the city. Often they are homeless, have no legal source of income, are mainly living in the city centre and resort to crime to get money for their daily dose of drugs.

In the inner city the law and order forces are mainly focused on this group: with surveillance, observation, arrests and the discouragement of concentration of users. In 1989 the 'street junky project' was launched for this group. If criminal drug-users have four run-ins with the police within a period of twelve months, they are given a choice; either serve the entire sentence for their crimes without probation, or submit to treatment to help them stop using drugs. If they do not complete the entire treatment, they have to serve their entire prison sentence.

Another method of maintaining law and order are the 'prohibition to be there' orders. The Major can order drug users and dealers who are disturbing the peace in a certain neighbourhood to leave the area and prohibit them from returning for a period of eight hours or fourteen days.

Small quantities of soft drugs are sold at 'coffee shops'. Amsterdam has approximately 350 of these coffee shops, of which some 100 are also bars. The policy of the city authorities is focused on freezing the number of coffee shops and limiting them to certain parts of the city. It is forbidden to sell hard drugs there, to cause nuisance, or to sell to anyone under the age of eighteen. Advertising and transactions above five grams are forbidden. A customer can only buy for his own use. Failure to adhere to these conditions, or having a selling stock of more than 500 grams of soft drugs, leads to official measures, the most severe of which is the withdrawal of the coffee shop licence. With this policy the soft drug trade in coffee shops has been decriminalised, and so has the soft drug user. Studies have shown that very few users go from soft to hard drugs, and the number of users has remained virtually the same since 1976.

2. MENTAL HEALTH SERVICES

First we describe Amsterdam's mental health care services from an historical perspective, a history which is an interesting but complex one. To understand this history it helps to look at inpatient services and community mental health services separately, and then try to understand how these two have attempted to reach each other, something which only recently turns out to be more successful. It is also of importance to realise that the hospital facilities for the city of Amsterdam have always been the responsibility of the Province of North-Holland. This was stopped in 1991.

2.1 History of the Service, 1562-1980

1562-1930

One of the first institutions for people with mental disorders in Amsterdam was a madhouse opened in 1562 and localised in the inner city at the Kloveniersburgwal (Vijselaar, 1997). In 1792 it was closed. From then a part of the Buitengasthuis, a general hospital just outside (or *'buiten'*) the inner city area, became the only institution for people with mental disorders in Amsterdam. Around 1840, when Amsterdam had 211,000 inhabitants, the Buitengasthuis gave places to about 150 psychiatric patients.

In 1842 this 'mental hospital' was visited by the Inspector of Health. After he had inspected all comparable institutions in the Netherlands, he concluded that the one in Amsterdam was the most terrible, dirty and inhumane. In 1843, one year after this visitation, the Province bought a big terrain 25 kilometres to the west of Amsterdam, situated at the border of the dunes, about 4 kilometers from the seaside. In 1848 the first building of this new mental hospital was finished and on 27 June 1849 some 162 patients travelled by coach from the Buitengasthuis in Amsterdam to the new one, called Meerenberg near the village Bloemendaal. This hospital had the whole province of North-Holland, including Amsterdam, as its 'catchment area'.

The medicalisation of mental disorders resulted in a rise of the number of patients from 500 in 1857 to 775 in 1866 and around 900 in 1882. Started as a 'medical institution' and being an example for many European visitors in its first years, the director of the hospital already in 1874 had to conclude that it had become a 'nursing home'. In 1884 the hospital put up about 120 patients above the capacity. In 1885 a new building was opened for 400 patients which was occupied in about another three years, mainly because a lot of Amsterdam patients hospitalised all over the Netherlands now returned to their 'city' hospital.

Because of capacity problems in Meerenberg, the Buitengasthuis continued to admit psychiatric patients illegally, and in 1883 it was decided to build a new hospital on the same terrain, the Wilhelminagasthuis. It was finished in 1893 and one of its three pavilions, the later infamous and stigmatised Pavilion III, was meant for patients with nervous and mental diseases. Here patients were selected; if a short hospitalisation seemed to be sufficient they were not transferred to Meerenberg.

Around 1900 the situation was again quite problematic. So in 1902 the new psychiatric hospital *Duin en Bosch* (Dune and Forest) was built for the area to the North of Amsterdam, and in 1910 another psychiatric hospital, the Valerius clinic, was opened in Amsterdam. Both Pavilion III and the Valerius clinic became University Clinics which could select the 'better' patients. From then onwards Meerenberg became more and more the mental hospital for the chronic and difficult patients of Amsterdam. In 1918 the reputation of Meerenberg had declined to such a low point that it was decided to change it's name. Since then it was called the Provincial Hospital near Santpoort or just **'Santpoort'.**

1930-1960

In 1931 around 3000 patients from Amsterdam were hospitalised in about 40 different psychiatric hospitals all over the country, with many of them in Santpoort, which had 1500 beds at that time (Amsterdam having 700,000 inhabitants). In that year a young doctor, the later well known social psychiatrist Querido, was given the task of visiting all these patients, to write a report about their condition and to make proposals about methods that could reduce the number of hospital admissions. In this period of economic recession, this

was mainly for financial reasons. Based on these visits, Querido (1935, 1968) developed the first independent social psychiatric service organised as a section of the Department of Mental Hygiene of the Amsterdam Municipal Health Service. The aim of this *'psychiatrie d'urgence'* was to reduce the number of admissions to mental hospitals by providing pre-care, outreaching psychiatric emergency services and aftercare. It was one of the very first examples world-wide of admission prevention by outreaching home visits. Through this acute psychiatric service Querido was able to bring the rising number of admissions, which had been around a 100 per year in the period 1926-1930, to a standstill.

In that same period other community mental health services began to be developed in Amsterdam. Together with Querido's social psychiatric service, they were examples for the rest of The Netherlands. In 1928 the first Dutch Medical Education Bureau, according to an American example, was opened. This bureau aimed at the prevention of psychiatric disorders by diagnosing and treating children with mental problems. At the beginning of the Second World War the first Institute for Multidisciplinary Psychotherapy was opened. At the end of this war the first Bureau for Personal and Family Counselling started.

In the fifties, community mental health care became partly organised along the lines of religious groups of the population. In Amsterdam, for instance, the Protestant (1948) and Catholic Foundation (1950) for Mental Health each organised under one roof the different ambulatory organisations; a Medical Education Bureau, a Bureau for Personal and Family Counselling and a Social Psychiatric Service.

1960-1980

In the sixties, Amsterdam's ambulatory mental health care services were composed of four regionalized Medical Education Bureaux, two independent Bureaux for Personal and Family Counselling, the two multifunctional foundations on religious bases, the Department of Mental Hygiene of the Amsterdam Municipal Health Service, and in particular for psychotherapy one Institute for Multidisciplinary Psychotherapy and one Psycho Analytic Institute. Thus services were organised according to different principles; religion, type of therapy, type of institution.

The sixties also was the decade which saw the first ideas concerning both non-denominational segregated ambulatory mental health care and regionalization. Finally in 1972 the Dutch Association of Ambulatory Mental Health Care (NVAGG) was founded, followed in 1975 by its Amsterdam counterpart, the Amsterdam Association of Ambulatory Mental Health Care (AVAGG). Using the American Community Mental Health Care centres as an example, both associations aimed at organising integrated multidisciplinary ambulatory mental health care, including social psychiatry, in Regional Institutes for Community Mental Health Care (RIAGG) for people of all age groups on a non religious basis. In contrast to the American example, these RIAGG's were not expected to have any beds nor day hospital facilities. Neither did they have any formal relation with the psychiatric hospitals. In fact they were organised to be a strong counterpower against the mental hospitals, which in that decade were seen as powerful and conservative institutions.

Regarding the further development of these mental hospitals, opposition increased in the seventies. Here the Amsterdam client movement has been one of the leading powers, an example for the whole of The Netherlands. They got their inspiration from authors such as Goffman, Laing, Szasz, Basaglia, Marcuse and Foucault. But there were also influential Dutch authors. Van Eyk-Osterholt (1972) described her 25 years of experiences with her twin-sister who had been hospitalised for mental illness since 1947. There was also the beginning of a critical atmosphere within the hospitals. In 1971 the psychiatrist Foudraine (1971) wrote a critical book about the situation in Dutch mental hospitals, and a few years later, in 1974, other professionals tried to implement radical changes in one of the biggest mental hospitals, the Willem Arntsz Foundation.

Partly as a reaction to this opposition, mental hospitals began a process of expansion, modernisation, differentiation and democratisation. The Netherlands in the seventies offered ample opportunities. Financial limitations were relatively scarce, health care as well as mental health care had the opportunity to grow. For the psychiatric hospitals this not only meant adding new functions, but also a renewal of old facilities. After many protests regarding the very bad conditions in the long stay wards, the Dutch government in 1977 started the nationwide project 'Re-housing Psychiatry', which aimed at the rebuilding of

the old wards of the hospitals. At that time this rebuilding had to be done on the same terrain. Ideas about deconcentration were still unknown.

In 1974 Santpoort had opened a special unit for acute admissions as well as a resocialisation unit for 360 patients. The years that followed made clear that the optimism about real resocialisation, which in this case meant reintegrating patients back from the dunes into Amsterdam, was in many cases too high. In 1979 the 360-bed resocialisation unit of Santpoort was divided into one unit for long stay patients and one resocialisation unit. One began to realise that a substantial number of the patients would not leave the hospital. At that time about 70% of the patients were already older than 60 and 50% older than 70 years. In 1980 a new 340 bed unit was build for chronic and psychogeriatric patients. Beside the psychogeriatric and nursing home services, Santpoort also started psychiatric services for young people. On the basis of the idea to become a multifunctional psychiatric centre the hospital also wanted to add a detoxification unit, as well as a clinic for patients with severe behavioural and aggressive disorders.

2.2 The period from 1980-1985

Financial arguments entered the health care discussion in the beginning of the eighties. It also became clear that the Province of North-Holland had too much hospital capacity, while the capital itself had a limited number of psychiatric hospital beds - just the two psychiatric university clinics, which for research and educational reasons had to be selective in their admission policy. Again the idea of bringing Santpoort back to Amsterdam, already born in the beginning of the seventies, was revitalised. In 1980 the government gave Santpoort permission to build a 350 bed psychiatric hospital on the terrain of the Wilhelminagasthuis. As a prelude, Santpoort took over Amsterdam's crisis centre and the centre for psychotherapeutic day treatment in 1981. However, plans for building new hospital facilities in the city were frozen in 1982. This was due to the formation of the RIAGG's, a nationwide discussion about a Moratorium on new hospitals, supported by some professors of social psychiatry, and more importantly with the new ideas about the organisation of

mental health care in the capital.

Hospital and community care: All in all the situation in Amsterdam in the early eighties was quite complicated. On the one hand the city's mental hospital Santpoort, still far away, was in a process of renewal. There were ideas about coming back to Amsterdam, but the building of new hospitals in the city was blocked. At the same time it was clear that the number of admissions was growing year by year, even more so for the percentage of involuntary admissions - the beginning of the 'revolving door' phenomenon.

On the other hand, the field of community mental health care was quite fragmented and further developments here also stagnated. The ambulatory organisations, the bureaux and institutes mentioned, were not enthusiastic about having a formal relation with the mental hospitals. This was to do with the type of patient population they served, mostly people with less severe psychiatric or psychological problems. One community service, the Department of Mental Hygiene, had frequent contacts with Santpoort. Together they had already made plans at the end of the sixties to build a Social Psychiatric Institution in Amsterdam of about 350 beds. This institution should have an optimal continuity between inpatient and outpatient services; acute psychiatry, observation, short treatment, and the pre- and aftercare of Querido. It should have the whole city as its catchment area and should include the acute admission wards until then located at the Santpoort hospital.

Apart from the relationship between hospital and community services, there were powers in favour as well as against regionalization. The Department of Mental Hygiene, the Institute for Multidisciplinary Psychotherapy and the Psycho Analytic Institute, for instance, did not want to break up and regionalize their services. However, following nationwide developments, in 1978 it was decided that with regard to the Regional Institutes for Ambulatory Mental Health Care (RIAGG) Amsterdam also should be divided into regions. It took another three years before it was decided to start five RIAGG's.

In a very difficult process the different ambulatory services mentioned so far were reorganised into these five RIAGG's which started to function in the early eighties. The

RIAGG's not only brought together professionals from different theoretical backgrounds, but also from different religious backgrounds, as well as professionals who used to work for patients of different age groups. This difficult integration process took many years, but as a result community mental health care became available for every inhabitant of the capital.

Only two services continued to work on the city level; the Psycho Analytic Institute and a part of the Department of Mental Hygiene, which in the evening and night-time hours still organised the *'Psychiatrie d'urgence'*, a city-wide crisis intervention service. It wasn't until 1994 that this service was finished, and the acute psychiatric service was organized on a regional level.

City and Province: The years 1982 to 1984 were a period of strained relations in which many heated discussions took place, and in which the Client Movement was most successful in organising sufficient political support for its new ideas about service delivery. Inspired by countries such as Italy, which at that time already had far-reaching examples of deinstitutionalization, progressive forces, young scientists, professionals, clients and citizens started to work together. They all had one strong driving force - namely, to break down the restrictive, dehumanising and isolating aspects of psychiatry. This meant, among other things, isolation rooms, electroshock therapy (sometimes used as punishment), and stigmatising treatments, all so very clearly represented by 'the mental hospital'.

Young committed scientists presented the document 'The Amsterdam way to a new style mental health care system' (van der Poel, 1982). A lot of their ideas were translated into a 'Note considering integral management of mental health care in Amsterdam', which was passed by the City Council unanimously in April 1984, a date that can formally be seen as the start of the Transformation Process in Amsterdam. It has been of great importance that this note was endorsed by the Province, and that the Provincial Deputy for Health and the Amsterdam Alderwoman for Health later on in that same year could agree on a Protocol in which the principles and structure of the mental health transformation process were described. It included among others new ideas about social psychiatric district teams,

RIAGG's and decentralised small Social Psychiatric Service Centres with about 20 to 40 beds.

For the further development of an integrated system of mental health care Amsterdam was divided into three, and not as for the RIAGG's five, regions. In 1983 the Dutch government had decided that Santpoort should have the definite responsibility for the Amsterdam region. So around 1984 an episode seems to be concluded. The psychiatric hospitals no longer had the opportunity to be renewed and rebuilt. They now had to deconcentrate, and for Santpoort that meant bringing back the services to Amsterdam, to the place where people were living.

2.3 "The Amsterdam Model"

To implement the system of regionalised integrated mental health care three types of committees began their work in 1984 (Gersons, 1992). Firstly, a Steering Committee for the co-ordination of the whole process. Secondly, an Advisory Committee of independent specialists which was given the task of advising the Steering Committee on specific issues. And thirdly, three Project Committees for each of the three regions. These committees consisted of representatives of the different mental health services, of the Platform for Mental Health Care and of the provincial mental hospital. Between 1984 and 1986 the Advisory Committee produced six recommendations which in 1987 were presented as a concluding report, under the intriguing title "The Amsterdam Model" (Advisory Committee, 1987).

Also in 1984 the collaboration of progressive forces, including some clients, was transformed into the Platform for Mental Health Care, which received a subsidy from the municipal authorities. This subsidy was spent on research, and between 1984 and 1989 a set of reports was published regarding 'The future of ambulatory mental health care in Amsterdam', 'Primary care', 'Partial hospitalisation, new style; a social psychiatric approach' and 'Supporting client participation in mental health care'. The three reports of the subregional Project Committees were accorded by the Steering Committee. They were

included as a separate Amsterdam chapter in the Provincial Plan for Mental Health Care, which was drawn up by the Minister in 1990.

Transformation: To summarise the principles underlying the Amsterdam transformation process one has to combine the different documents mentioned so far. Here a distinction will be made between the client level, the service level and the service delivery level (Gersons, 1992; Schene, 1992):

Considering clients:

- clients and client organisations will have influence on all the different levels,
- service delivery is individualised, need based and tailor made,
- clients stay as much as possible within their own living circumstances,
- stigmatisation and marginalisation are opposed,
- the repressive function of psychiatry is opposed,
- chronic mentally ill, migrants and women are prioritised.

Considering services:

- services are regionalised and evenly distributed over the city
- services are small scale
- only a minimum of services are organised on the level of the city as a whole
- stimulation of collaboration between primary care and mental health care
- emphasis on outpatient and semimural services
- integration of ambulatory, semimural and inpatient services
- admissions to inpatient services are minimised by an outreaching approach, partial hospitalisation and time-out facilities
- a segregation of living and treatment
- differentiation in housing accommodations
- emphasis on rehabilitation
- continuity of care
- development of community support systems

Considering service delivery:

The city will be divided into three regions of about 200,000 inhabitants each. Each region offers comprehensive and integrated mental health care which includes:

- ambulatory district teams: outreaching and offering social psychiatric care regardless of where patients are staying
- Social Psychiatric Service Centres; clinical crisis interventions, short treatments, either using inpatient or preferably day treatment services, a maximum of 40 beds
- hotel accommodation: for those patients that normally live on their own but temporarily need more protection or safety
- a differentiated system of sheltered living accommodations
- day care and rehabilitation services

During the last decade these principles, which nowadays of course are well known in community psychiatry, have been critical for the transformation process. They were very much in accordance with the policy of the Dutch Government, which in 1984 published the white paper 'Public Mental Health' which included a lot of these principles.

2.5 Mental health service evaluation

Although one of the reports of the Advisory Committee considered Research, there has never been a thorough and well-designed evaluation of the transformation process in Amsterdam. However, a lot of smaller projects have been conducted, which taken together offer information about different aspects of the transformation process.

In 1992 the twenty mental health care services formed a section within the SIGRA, the Combined Health Services for the Amsterdam Region, including a hundred health care institutions altogether. As preparation for a Regional Vision on mental health care, two activities were undertaken. Firstly, in 1993, a report was published called 'The Amsterdam Model halfway' (Janssen, 1993). It is based on about 250 documents considering mental health services, mostly research reports, and on 52 interviews with key figures. It is an evaluation of the implementation of the ideas underlying the transformation process.

In 1992 a Vision group was installed which was given the task of investigating and evaluating the principles of the transformation of Amsterdam's mental health care on the actual provision of services, and of formulating new principles according to which further developments could be checked. In 1993 they published 'Starting points for mental health care in Amsterdam in the Nineties' which includes an evaluation of the transformation process. Both reports were translated into the Regional Vision on Amsterdam Mental Health Care in the Nineties.

Since 1993 new research reports have been published. The description in the next paragraph is based on the results of the different research projects conducted in the last ten years, as well as on statistical data from the SIGRA.

2.6 Recent history: 1986-1996

The 1984 Protocol of the City and Province was received with ambivalence by the Santpoort hospital. Deconcentration was necessary, but breaking the hospital up into small units, or even ideas about integration and fusion with the other mental health care services in Amsterdam, was at that time not acceptable. In 1985 the Advisory Committee had proposed that services working in the same region should fuse into a new corporate body responsible for the quality and continuity of all mental health care services in that particular region. Although Santpoort had opened three outpatient departments of psychiatry in Amsterdam in 1985, the new Board of Directors in 1986 wrote a letter to the three regional Project Committees stating that the contribution could only be a transfer to Amsterdam of some of the Santpoort services. However these should always be recognisable as parts or annexes of Santpoort.

Returning to Amsterdam: At the same time Santpoort made plans for the return to Amsterdam of the first groups of long-term patients. Half a year earlier than expected, and forced by heating facilities that broke down in the old wards during wintertime, Santpoort had to move 36 long-term patients to flats in the Bijlmermeer (South-East) within a period of six weeks. In this sheltered living project, called 'the *Kempering'*, patients lived in one-

to four-person apartments on the lowest layer of some big flats. There was a nursing office, an apartment for other staff members, a day care centre and a kitchen. Although within half a year 12 patients returned to Santpoort, this project was pioneering in demonstrating that some of these patients were able to live a far more independent life than was expected while they were still hospitalised in the dunes.

With regard to the living accommodation for long-term patients, the Advisory Committee in 1985 wrote that these services should be small scale, in the neighbourhood where patients used to live, situated as much as possible in normal houses and differentiated according to three levels of care dependency; the self care of patients in Category I being sufficient, in Category II moderate, while Category III meant they were in need of some form of nursing.

In October 1987 a second group of 74 chronic patients moved to a five floor building in Amsterdam, the *Surinameplein,* close to the town centre, and until then used as an old people's home. These patients started to live in groups of 15 with a sitting room, facilities for washing and a toilet all for their own use. Each floor had a nursing office.

These two projects, *Kempering* and *Surinameplein,* have been evaluated by Duurkoop (1995). He concluded that the 'new' lives of patients in comparison to their 'old' ones showed less symptomatology, better functioning, more social contacts, less use of seclusion, while using fewer beds on closed units and the same amount of medication. They were more satisfied with the new style of living, although integration within the neighbourhood was not successful. He concluded that rehabilitation should get far more attention.

In the years 1984 to 1993, the number of sheltered living homes in Amsterdam rose by 390, from 365 (at that time called psychiatric nursing homes with 24-hour nursing) to 755. Of these 390 places, 268 were created by substitution of Santpoort long stay hospital beds, while the target of the Advisory Committee had been 480 of these substituted places for a 5-year period, about 200 more. The other 122 places were organised by the Regional

Institute of Sheltered Living (category I and II), an organisation independent of the mental hospitals. Another target not realised was the percentage of places situated in normal houses, which should have been the majority, but was only 38% in 1993. For patients from categories I and II the segregation of living and support/nursing had been realised in all cases, according to the targets set. Patients living in Category III accommodation all received permanent and intensive support.

Ambivalence: Santpoort continued to vacillate between moving to Amsterdam and staying in the dunes. In 1986 a unit for psychomotor therapy was build on the hospital terrain, and even as late as 1990 a big new kitchen was opened, both for a population of 1200 patients. At the same time the first Social Psychiatric Service Centre was opened in 1988 in the former Department of Cardiology of the Wilhelminagasthuis. However, this 'return to Amsterdam' was not well prepared for, and the starting period has been a difficult one, with suicides of patients and a lot of sick-leave amongst the personnel (Cohen, 1995).

In 1989 the Province decided to privatise the Santpoort hospital. In 1991 the hospital was officially taken over by two new organisations, the Frederik van Eeden Foundation working in the region East/South-East and the Psychiatric Hospital Amsterdam for the region Centre/Old-West/North. In 1992 the two new organisations decided to return all Santpoort buildings/services to the city within a ten year period. In the third region, South/New-West, the hospital function was fulfilled by the Amsterdam Psychiatric Centre, a fusion of the Valerius clinic and the J.C. de Keijzer Foundation.

2.7 Client participation

In the beginning of the nineties the organisation of client influence and participation changed. The Platform for Mental Health Care slowly lost its political power. The Dutch health care system as well as the Department of Health had discovered 'the client' as a new party. Competition entered the health care system, clients now became health care consumers whose demands had to be made known and whose satisfaction had to be measured. For the government a reduction in costs became increasingly important, and

critical client organisations were seen as being of great potential help in this process. The LPCP (National Patient Consumers Platform) started in 1989, and for the capital the APCP (Amsterdam Patient Consumers Platform) started in 1990. This organisation is a collaboration of all health care consumer organisations, which each have a particular section, in our case Mental Health Care. Subsidies now went to this new platform which took over the responsibilities of the old Platform.

2.8 Social Psychiatric Service Centres

The first Social Psychiatric Service Centre (Centre/Old-West/North) has been evaluated. Dekker (1996) showed that, in comparison with Santpoort, patients were referred at an earlier stage of their decompensation, admissions were less urgent and occurred more during day time hours, patients were less secluded, there was less violence, patients were more satisfied and the percentage of day treatment was significantly higher than in Santpoort. In terms of length of stay, symptom reduction or functioning there were no differences.

In 1994 the admission ward of Santpoort was closed and the second and third Social Psychiatric Service Centres were opened in Amsterdam-North and Amsterdam-East. Other centres are in preparation in the regions South-East and South/New-West. The one in the Centre so far has been cancelled.

Looking back at the plans with regard to these centres one may conclude that they are functioning for a region of about 100,000, they are small scale (not more than 50 beds), they are successful in substituting inpatient for daypatient care, but a further substitution into ambulatory care so far has not been successful. Although the length of stay originally had a maximum of three months, this has changed, partly because the continuity of care into sheltered living accommodation stagnates. The centres have certainly changed the geographical distance between house and hospital. In 1994 already 68% and in 1995 74% of all admissions were within the region where the patient was living.

Nevertheless the centres are criticised because they still function too much as small hospitals, with not enough attention paid to ambulatory mental health care, being a form of trans-institutionalisation instead of de-institutionalisation. The transformation process has been successful in implementing these centres, but they have become too dominant. Social psychiatric approaches still have to be developed in a more stringent way. Continuity of care and outreach require far more attention, especially in relation to the RIAGG's.

2.9 Day care centres

With regard to day care centres the situation has changed substantially over the past decade. Before 1985 only three of these centres were available, all controlled by independent foundations. Between 1985 and 1993 nine new centres were opened (including a Fountain House clubhouse), most of them connected to a psychiatric hospital, RIAGG or sheltered living accommodation. Together they offer about 3500 half-day units (morning/afternoon) of day care per week. However, for a total of about 8500 estimated long term psychiatric patients living in Amsterdam this seems insufficient.

In its 1993 report 'Starting points for mental health care in Amsterdam in the Nineties' the Vision group also concluded that since the start of the transformation process differentiation and deconcentration have been implemented. More individualised care is possible now, although a social psychiatric approach needs further development. Although regionalization has in some measure been successful, continuity of care has to be developed more rigorously. Reasons for stagnation on this point are: that ambulatory district teams have not been developed; and that collaboration between services such as RIAGG, outpatient departments, organisations for sheltered living and day care centres is rather low, let alone the managerial and administrative integration or fusion between the different services. There is still considerable overlap between the care packages of the different services, while institution exceeding, or transmural care programmes have not been developed.

One of the aims of the Amsterdam Model was to decrease the pushing-out or expulsion of psychiatric patients from the community in which they were living. Although the

transformation certainly has done a good job in counteracting these processes, there is nevertheless a growing group of people with psychiatric disorders who are not reached by the mental health care system.

An important event took place in 1993 when a psychiatric patient living in a working-class quarter killed a child. So far services had not been able to have any contact with him. This 'Vrolikstraat murder' initiated a lot of discussion in the media about a failing mental health care system. The Vision group also concluded that trying to lessen the amount of coercion seemed to have resulted in insufficient responsibility towards those people who do not seek mental health care themselves. This murder had far-reaching consequences.

Santpoort: At this moment in time the former Santpoort still houses long-term patients in pavilions called De Meerlanden, Ouderenkliniek, Meerzicht, West-Friesland, Evertsenkliniek (for intensive treatment of patients with behavioural disorders) and Wieringerland. Other inpatient capacity has been relocated to Amsterdam as Social Psychiatric Service Centres, sheltered living accommodations, home care and nursing homes. A further reduction of beds (see paragraph 4) is planned, as well as substitution to services in Amsterdam. When housing facilities have been created the Ouderenkliniek, for instance, will be placed in the new Centre for Neuropsychiatry in South-East. Also in the coming years the region East/South-East will have its second Social Psychiatric Service Centre (East: 64 places, South-East: 64 places), care at home projects, new living accommodations and a forensic psychiatric clinic which will include the clinic for intensive treatment. The two long stay pavilions belonging to Psychiatric Hospital Amsterdam (region Centre/Old-West/North) now still in Santpoort (Wieringenland and West-Friesland) will be transferred to Amsterdam as services for long term care. To finance the return of these Santpoort services to Amsterdam a further reduction of the total capacity was necessary. About 117 beds will be closed. The financial reserves are now available to start the building of new facilities in Amsterdam.

3 HEALTH CARE IN AMSTERDAM: FACTS

In this paragraph facts about the current (mental) health care system will be given. To understand these data some background information is necessary. All mental health care (except psychiatric departments of general hospitals) is under one form or type of insurance. This insurance, however, for budgetary reasons, makes a distinction in intra-, semi- and extramural care. The intramural compartment includes organisations or institutions which by law are called General Psychiatric Hospitals or Addiction clinics. The semimural compartment includes the Regional Institutes for Sheltered Living, which organise a variety of living accommodation, mostly in the categories I and II mentioned. The extramural compartment includes the Regional Institutes for Ambulatory Mental Health Care (RIAGG), psychiatrists and ambulatory addiction services. Of the total annual budget intra-, semi- and extra- mural respectively get 71.2%, 5.7% and 23.1%.

Psychiatric hospitals nowadays offer a differentiated package of care; inpatient, daypatient, outpatient, living accommodation (category III) and home care or other care innovations. Although paid from the same insurance, the circuit for addiction services is organised totally separately from mental health services.

3.1 Regional Institutes for Ambulatory Mental Health Care (RIAGG's)

The RIAGG's have three departments or sections; children/adolescents, adults and 60^{+}. Their target population very much overlaps with that of the outpatient departments of psychiatry connected to a psychiatric hospital or to a department of psychiatry of a general or academic hospital. The 7x24-hour crisis intervention services are part of the RIAGG remit. So far regionalization has been only partly implemented. It is not yet clear exactly what amount of the total capacity will be earmarked for the three regions, or what type of functions will be organised for bigger or smaller (sub)regions.

3.2 Specialists and hospitals

Amsterdam has two academic hospitals (1833 beds) and five general hospitals (2245 beds; 311 per 100,000 inhabitants). The academic hospitals have a catchment area much larger than Amsterdam. The total number of medical specialists living in Amsterdam is 1409, and the number of residents is 719. Of these 2128 some 322 are psychiatrists or psychiatric residents (15.1%). The number of psychiatrists as well as other disciplines serving just the Amsterdam population is not known.

Psychiatric departments/hospitals: in-patient and day-patient

For each Amsterdam sub-region a general psychiatric hospital is functioning:

- East/South-East (200.000 inhabitants, Frederik van Eeden Foundation):
  374 inpatient and 5 daypatient places
  64 home care and Category III living accommodations
- Centre/Old-West/North (260.000 inhabitants, Psychiatric Hospital Amsterdam):
  564 inpatient and 59 daypatient places
- South/New-West (240.000 inhabitants, Psychiatric Centre Amsterdam):
  307 inpatient and 90 daypatient places

The following departments are not regionalized and have a bigger catchment area:

- Psychiatric Department Academic Medical Centre:
  60 inpatient and 34 daypatient places
- Psychiatric Department General Hospital St Lucas:
  30 inpatient and 16 daypatient places
- Jellinek centre (Addiction):
  211 inpatient places
- Nursing home for psychogeriatric patients: 360 beds

The number of psychiatric inpatient places (not including child and adolescent psychiatry) for Amsterdam alone was 1502 in 1995, for age groups 2.08 per 1000 and for those 20 years or older 2.6 per 1000.

For the year 2000 according to the law the following number of inpatient places per 1000 have been allowed:

- psychiatric hospital and psychiatric department of general or academic hospital: 1.4 (1152 inpatient places)
- categorical psychiatric hospital: 0.17 (inpatient places)
- free margin: 0.20 (165 inpatient places)
- special big city raise: 0.13 (107 inpatient places)

The total number of 1502 in 1995 has to be decreased to 1259 (1107+107) in the year 2000. This means a reduction of 243 inpatient places. The free margin will be used for child and adolescent psychiatry, addiction services and care innovation projects (non inpatient).

3.3 Sheltered living

Three types have to be distinguished. Firstly, those that are administered by the Regional Institutes for Sheltered Living (487 places). Secondly, the psychiatric living accommodations (268 places), which are substituted psychiatric hospital beds. These are still budgeted as an inpatient place (and calculated as such), while in fact they are living accommodations. Thirdly, there are three social boarding houses (170 beds) which were set up in the last three years especially for homeless people with psychiatric disorders.

3.4 Ambulatory and outpatient

Amsterdam has five RIAGG's (North, East, South-East, South/New-West and Centre/Old-West). Together they have about 45,000 new clients a year, including all age groups. There are five outpatient departments of psychiatry for adults, connected to Psychiatric Hospitals or Psychiatric Departments of General/Academic Hospitals. The exact number of new patients here is not known (estimated at 9000). Psychiatrists working independently from

services have about 3000 new patients a year.

3.5 General practitioners

The total number of general practitioners in Amsterdam is 479 (1507 inhabitants per general practitioner; 67.3 general practitioners per 100,000 inhabitants). The density of general practitioners in the different districts varies greatly. It becomes more and more difficult to get general practitioners for the old, low income districts.

3.6 Municipal Health Service

The core of the city's public health care is the municipal health service (GG&GD), a service founded in 1901 to replace the obsolete system of doctors for the poor. After World War II the service was expanded into a modern department for collective and preventive health care. It combats infectious diseases, has an ambulant service, provides health care for Amsterdam youngsters from the age of 0 to 19, and is responsible for the police physicians, Aids-research, care for the homeless, drug addiction facilities, tuberculosis testing, the care of the medical environment, and so forth. The municipal health service advises city authorities on the health aspect of municipal policies and has begun to work in close conjunction with the new administrative units in the capital, the district council.

3.7 Addiction aid programmes

A number of addiction aid programmes have been developed. The methadone programme of the municipal health service provides addicts with a daily dose of methadone and enables this service to maintain regular contact with them. Through a mobile dispensary, a number of stationary ones, and from some general practitioners, half of the approximately 6000 hard drug addicts receive a daily dose of methadone. The programme enables drug addicts to continue to function within society in a more or less normal fashion. To reduce the spread of Aids and hepatitis B there are ten sites where addicts can exchange used needles

for new ones free of charge. Only 40% of the addicts inject drugs. Most of them inhale drugs, and this means less of a risk for transmitting Aids or hepatitis B.

Miscellaneous: The number of dentists is 480 (1504 inhabitants/dentist), the number of pharmacies is 86, the number of social nurses is 187 and the number of beds for the mentally handicapped is 418.

4. MENTAL HEALTH SERVICE UTILIZATION

When all admissions to inpatient, daypatient and sheltered living accommodations are added, the admission rate per 1000 inhabitants is 6.04 per year for Amsterdam and 4.68 for the Netherlands; 29% higher for Amsterdam. When the number of new clients per year in the RIAGG's are added this percentage rises to 43%.

For the RIAGG's the percentage of new clients per 1000 in 1989 was 15.4 for men and 20.5 for women. For the Netherlands these figures were 12.0 and 14.7. More interesting is the number of contacts per client, which has a mean of 8.2 for The Netherlands and 16.8 for Amsterdam.

The number of admissions for schizophrenia per 1000 inhabitants in the age group 20-34 years is 0.6 for The Netherlands and 2.4 for Amsterdam. Also for the category Other Psychoses the number is significantly higher (0.45 vs. 0.90). Ethnic groups differ significantly. For each group the percentage of the total population, the percentage of all admissions (2.883) and the total number of admissions per 1000 inhabitants is as follows:

Ethnic group	% of population	% of admissions	admissions/1000
- Dutch	58.1	76.3	5.24
- Surinam	9.6	7.5	3.13
- Antilles	1.5	1.2	3.43
- Turkey	4.3	1.5	1.39
- Morocco	6.5	3.7	2.29
- South-europe	2.2	0.9	1.61
- other industrialized	8.1	3.7	1.85
- other non-industrialized	9.7	5.0	2.06

The ethnic groups are hospitalised less often, if admitted it is more often involuntary, more often with a diagnosis of schizophrenia, and the length of stay is shorter in comparison with Dutch people.

4.1 Involuntary admissions

The first years of the transformation process (1985-1991) showed a decline in the number of involuntary admissions of 44%. This trend has changed over the past years. In Amsterdam the percentage of patients involuntarily admitted rose over the years 1992 to 1995 from 6.1%, to 8.3, to 13.3 and to 15.9. The number of involuntary admissions per 1000 inhabitants is 0.60 in Amsterdam and 0.31 in The Netherlands. When only admissions with a length of less than 6 months are considered the percentages of involuntary admissions were 1993: 12%, 1994: 18% and 1995: 21%.

Regionalization: The figures show that the percentage of people that use mental health care in their own region rose from 61% in 1992, to 64% in 1993 to 67% in 1994. Of all the Amsterdam people that had to be admitted 10.1% were admitted outside the city. Those were especially people in the age group 20 to 34 years, probably students or other new youngsters.

Costs: The Insurance Company has conducted a study on the development of costs for

mental health care after the introduction of the Amsterdam Model. Between 1984 and 1989 they calculated a reduction of 4.5%, and they expect this reduction will increase to 7% in 1993. However, when mental health care costs per insured person are compared, the price for Amsterdam is 150% of the price in The Netherlands as a whole.

5. CURRENT ISSUES

Ten years of transformation and care innovation in Amsterdam has changed a lot in the delivery of mental health care. We will summarise some issues and detect aspects which have been less successful or underexposed and in need of more attention in the years to come. Of course one should realise that during the last decade there have been major sociological, political, financial, technical and many other changes which have altered individual demands, needs and lifestyles, as well as interpersonal ways of behaviour, acceptance and support. Society has become more individualistic and less tolerant towards deviant behaviour. At the same time the percentage of people using ambulatory mental health care has increased tremendously during the last 15 years. These processes have been active during the period in which the Amsterdam Model was implemented.

There are at least two types of services of the Amsterdam Model that so far have to be considered as failures. Both the social psychiatric district teams and the hotel accommodations have not been realised. In theory the district teams were the core of the Amsterdam Model, being outreaching, flexible and supportive. They should have offered a variety of treatment methods for a target population of about 50-70,000 people. The teams had to be composed of professionals from the RIAGG's and the Social Psychiatric Service Centres, being part of the psychiatric hospitals.

Why did they fail?

- **First** it is not surprising that professionals connected to different types of services do not work together without co-ordination, and this is what has been lacking.

- **Second** in the mid-eighties the RIAGG's were still in their infancy, trying to bridge the many differences between heterogeneous groups of professionals. They were not in need of another reorganisation. By law the RIAGG's have the task to offer

outreaching acute and social psychiatric care. However, on the one hand they were not yet equipped for that task, and on the other their budgets were too low to offer it in such an intense way as was intended for the district teams. The long history of opposition between the psychiatric hospital, the ambulatory services and the Department of Mental Hygiene of the Municipal Health Service was not a good basis for such a new joint task as the district teams.

- **And last but not least** these teams were also criticised by the clients. In their view the teams would ultimately result in a further 'psychiatrizing of society'.

The hotel accommodations were meant for those patients in need of some rest and support, temporarily not able to sleep in their own house or not having a house at all. Underlying it is the principle of a separation of 'treatment' and 'stay'. Instead of this facility, partial hospitalisation has become very popular during the eighties (Schene 1986, 1988), in particular as an alternative for full time hospitalisation. The so called 'bed on receipt' has been implemented widely in The Netherlands. If patients are admitted, for instance, to a Social Psychiatric Service Centre they occupy a bed, but this does not necessarily mean they use it. If they want to sleep in the clinic, they can. If they are able to sleep at home they do. And if they have to return to the clinic they always can because their bed is vacant. Till now insurance companies are willing to pay these 'beds' (or as some call them inflatable beds) although they know that they are occupied at night-time only for a certain percentage of nights.

The Amsterdam Model has also been criticised for its selectivity. It has been labelled a social psychiatric model which paid too little attention to youth (in particular adolescent psychiatry) as well as to psychotherapy, psychosocial problems, addiction services, severely handicapped patients, patients with double handicaps (somatic/psychiatric) and patients with severe behavioural disorders (aggressive/ forensic). The return of Santpoort to the capital was the great topic, but little attention has been paid to the several hundreds of long term patients from Amsterdam that were hospitalised in psychiatric hospitals in other provinces than North-Holland. Should they return as well? It seems they were not incorporated in the calculations.

From another perspective the transformation process has been criticised for being too much

oriented on the organisation of services, especially hospital services, without realising that behind all these organisations professionals had to do the job. The formation of the RIAGG's especially has received far too little attention in the original ideas. The different types of services these RIAGG's offer by law (including 7x24 hour crisis intervention, prevention, public mental health, consultations to public services etc.) were not worked out in the Amsterdam Model. In the time the Model was designed, the RIAGG's were in their infancy. The criticism that was the driving force behind the Amsterdam Model was in fact a criticism of the psychiatric hospital structure of the seventies and not a more modern one in which new developments were integrated. The dominance of organisational solutions also did not take into consideration the very difficult, conservative and limiting laws and regulations. New corporate bodies were mentioned as a solution to long-standing diverse interests. So far such bodies are still not in existence. This crosses also the substitution of services from, for instance, a psychiatric hospital to a RIAGG. We have described examples of substitution from intra-, to semi-, to extramural but these were always within one type of institution.

One cannot blame the designers of the Model for having only limited knowledge about rehabilitation, which was also in its infancy at that time. However, further developments have shown the great importance and need for that type of service. It is clear that the Social Psychiatric Service Centres, the sheltered living accommodations and the day care centres, like elsewhere, silt up with long term users. What is needed is a very strong impulse towards the further development of rehabilitation techniques and practices.

Evaluations of the Model have recently enumerated groups of vulnerable people which need more attention: patients who for a long period of their lives are in need of psychiatric care and who formerly would have been hospitalised for many years, homeless people with severe psychiatric disorders, patients with a psychiatric and addiction disorder, patients from ethnic minorities, victims of sexual abuse or aggression and young people with psychiatric problems. Most of these groups have become more pronounced during the last ten years. Special programmes have been developed and are now being implemented in the different regions.

Much attention is given now also to initiatives to reach those long term patients who have great difficulty in matching the type of mental health care we regularly offer them. From the perspective of care providers they are called 'care avoiders'. In each of the three regions projects have been organised since 1993-94 to reach this group by active outreach strategies. They try to contact patients, to help them with very practical everyday problems, to start some rehabilitation and to refer them to volunteers who help to build up a network. Some of these projects also are active in trying to work with the homeless mentally ill, in the guest houses they stay, on the streets, and in the social guest houses; psychiatry takes to the streets now, also in Amsterdam (Cohen, 1990). Sometimes these initiatives are taken by the RIAGG's, sometimes by the decentralized psychiatric hospitals, and also by the former Department of Mental Hygiene which still has a responsibility for public mental health, and which in 1988 started a special team called Safety Net & Advise.

Recent history has also shown that in a dehospitalised system, mental health care can only be successful if it works together with other authorities, like housing associations, care for the homeless, (voluntary) work associations, community centres, legal advice centres, education etc. Because of the close relationship with mental health care policy, this has become known as 'flanking policy'. The main purpose of this policy is to organise a much larger safety net and more support for those vulnerable people who are constantly balancing on the border of society, and who can be the cause of a lot of nuisance and inconvenience for other people living in the neighbourhood. Safety Net & Advise, for instance, supports different district projects which have been called 'Extreme Nuisance'. Here a social psychiatric nurse, if necessary with a police officer, visits those people who cause a lot of annoyance to their neighbours and tries to find solutions.

Another point which has not received enough attention is consumer participation. Although consumers have played an important role in the development of the Amsterdam Model, their power and influence on the present services are far less pronounced. On the regional level, on health care policy, as well as in individual cases this influence should increase. Consumers besides insurance companies and care providers should really be one of the three parties involved. Since 1996 the City of Amsterdam and the Insurance Company

together finance a new way of client influence, the Client Panel. By this method users of mental health services are interviewed, or they fill in questionnaires around a specific topic. So far two reports have been published, one on Acute psychiatric care and one on Living Accommodations. The first one, for instance, showed some major problems; crisis intervention services have thresholds which for many users are too high. Each of the three regions needs a crisis intervention centre which is organised separately from psychiatric services. And although in organisational terms a regional approach is acceptable, users from all over the city must have the opportunity to use these centres. These centres should not be restricted to users from that particular region.

6. CONCLUSION

We described the development, transformation and current status of Amsterdam's mental health care services. It may be concluded that in the past ten years a lot of changes have been realised. The former psychiatric hospital Santpoort will finally be closed in 2001. Then all of its services will have returned to Amsterdam, most of those in a decentralized and innovative way.

However, currently there are some major concerns. First, although regionalization has been implemented, the different mental health care services operating in a particular region are still not integrated into new corporate bodies. Here the great differences in historical backgrounds as well as budgets available for intra-, semi- and extramural services of course are a major obstacle. However a central co-ordinating and powerful body for the city as a whole has also been missing.

Second it is evident that although Amsterdam has a lot of services there is nevertheless an increasing group of people with needs that are not met. Most of them have a combination of severe psychosocial and psychological problems which do not match with existing health care and social services. Either these people, for whatever reason, do not want to be in contact with services, or the services are organised in such a rigid way that they do not meet the needs of these specific groups. Many of them are marginalised and extruded

people who seem to be the victim of a society that is over-regulated and over-organised, and does not leave space for those who do not, or do not want to fit into these systems.

One of the challenges for the near future is to find a good balance between an increase of the overall quality of our society, and in particular our cities, on the one hand, and on the other an increase of the quality of life of those people who have disabilities or handicaps that make adapting to the high demands and the strict rules and regulations of such a society a hard job for them. They ask for more deregulation, flexibility, solidarity and special attention.

REFERENCES

Advisory Committee Mental Health Care Amsterdam. Het Amsterdamse model (The Amsterdam Model): eindverslag van de adviesgroep Geestelijke Gezondheidszorg Amsterdam. Amsterdam; 1987.

City of Amsterdam. Amsterdam: facts and figures. Amsterdam: City of Amsterdam Feature Services; 1996.

Cohen D, Sanders HE. Day-program-based treatment in the Amsterdam city centre. International Journal of Social Psychiatry 1995;41:120-131.

Cohen NL. Psychiatry takes to the streets. Outreach and crisis interventiuon for the mentally ill. New York: Guilford Press; 1990.

Dekker J. Het Amsterdamse Sociaal Psychiatrisch Diensten Centrum (the Amsterdam Social Psychiatric Service Centre): een vergelijkend onderzoek naar een multi-functionele eenheid en de regulier 24-uurs zorg [dissertation]. Amsterdam: Universiteit van Amsterdam; 1996.

Duurkoop P. Terug naar Amsterdam (Back to Amsterdam): longitudinaal onderzoek naar het functioneren van chronische patiënten in nieuwe woonsituaties. Amsterdam:Frederik van Eeden Stichting; 1995.

van Eyk-Osterholt CA. Laten ze maar voelen: vijfentwintig jaar belangenbehartiging voor een verpleegde. Amsterdam: van Gennep; 1972.

Foudraine J. Wie is van hout? (Who is made of wood?) een gang door de psychiatrie. Bilthoven: Ambo; 1971.

Gersons BPR, van de Graaf W, Rijkschroeff R, Schrameyer F. The mental health care transformation process: the Amsterdam experience. International Journal of Social Psychiatry 1992;38:50-58.

Janssen M. Het Amsterdamse model halfweg (The Amsterdam Model Halfway): een tussenstand van de GGZ-hervormingen in de hoofdstad. Utrecht:Nederlands centrum Geestelijke volksgezondheid; 1993.

van der Poel E, van Haaster H. Een Amsterdamse weg naar een GGZ nieuwe Stijl (The Amsterdam way to a new style mental health care system). Amsterdam: SISWO; 1982.

Querido A. Community mental hygiene in the city of Amsterdam. Mental Hygiene 1935;19:177.

Querido A. The shaping of community mental health care. British Journal of Psychiatry 1968;293-302.

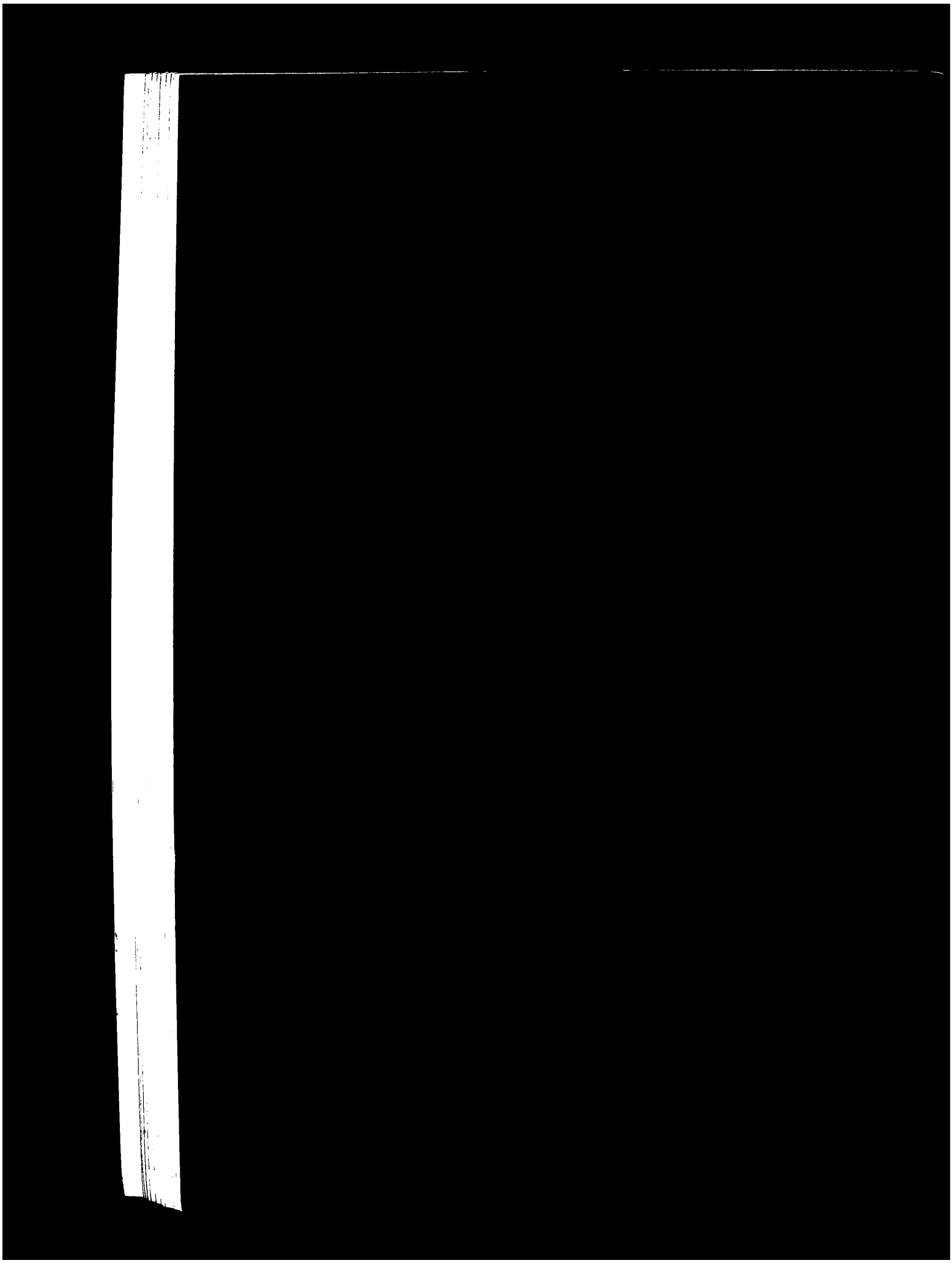
Reijneveld SA. De gezondheid van de Amsterdammers (Health of the Amsterdam people): eindrapport van het project Gezondheidsprofiel Amsterdam. Amsterdam: Gemeentelijke Geneeskundige en Gezondheidsdienst Amsterdam; 1994.

Schene AH, van Lieshout P, Mastboom J. Development and current status of partial hospitalization in the Netherlands. International Journal of PartiaHospitalization 1986;3:237-246.

Schene AH, van Lieshout P, Mastboom J. Different types of partial hospitalization programs: results from a nationwide study.Acta Psychiatrica Scandinavica 1988;75:515-520.

Schene AH, Henderson JH, Knudsen HC, Rijkschroeff R, Thornicroft G. The evaluation of mental health care transformation in the cities of Europe. International Journal of Social Psychiatry 1992;38:40-49.

Vijselaar J, editor. Gesticht in de duinen (Asylum in the dunes): de geschiedenis van de provinciale psychiatrische ziekenhuizen van Noord-Holland van 1849 tot 1994 Hilversum: Verloren; 1997.



CHAPTER 2

THE CITY OF BALTIMORE, USA:
THE BALTIMORE EXPERIENCE

Stephen T. Baron[1], Deborah Agus, Fred Osher, David Brown

(1) Stephen T Baron, President Baltimore MH Systems Inc
201 w Baltimore Street, Suite 1340
Baltimore, Maryland 21202, USA

Tel: 00 1 410 837 2647
Fax: 00 1 410 837 2672

CONTENTS

1. THE CITY OF BALTIMORE, USA

Baltimore City is the thirteenth largest city in the United States. It is located on the eastern seaboard of the United States in the State of Maryland 37 miles (60 kilometers) from Washington, D.C. and 196 miles (315 kilometers) from New York City. Baltimore is one of the oldest cities in the U.S. and in 1997 celebrates the bicentennial of its incorporation. The city is governed by a Mayor and a 19 member City Council which is elected every 4 years.

Over the past 40 years, similar to other urban areas in the U.S., Baltimore has experienced a decline in population. Once the largest political jurisdiction in the state of Maryland, with 939,024 or 25% of the State's population, Baltimore is currently the fourth largest subdivision in the state with a population of 692,800 or 14% of the State's population. The majority of the individuals residing in Baltimore City are African-American (about 60%) with Caucasians making up 38% and other races the additional 2%. Baltimore's 14,652 businesses employ 311,161 workers. Manufacturing accounts for 10% of the City's workforce and the largest employer is the Johns Hopkins University and Hospital System.

1.1 Indicators of Poverty

Baltimore is home to the largest concentration of poor people in Maryland. About one-half of the state's poor people reside in the City of Baltimore. The population of Baltimore City is about 30% of the metropolitan area (the city and the 5 surrounding counties) but the City is home to almost 68% of the region's poor. In 1960, the median income of City families was 91.2% of the metropolitan area median family income while in 1990 the income of City families was 66.9%. (Baltimore: Past, Present and Future Trends and Projections, pg. 15). The poor are overwhelmingly children from single parent homes, African-American female single parents, and the elderly and disabled. (Baltimore: Past, and Future Trends and Projections, pg. 16).

The elderly (over 65 years old) make up 13.7% of the City's population. Over 40% of the elderly population living in the city are disabled, while 32.5% of the elderly state-wide are disabled.

In 1992, 21.5% of the households in the city had incomes below $10,000 compared to only 9% of households in the state of Maryland, and 15.6% of the households in the City had incomes above $50,000 while 34.7% of households in the state were above $50,000. (Baltimore City, Maryland, Brief Economic Facts) In 1991, the City's unemployment rate of 9.4% was the highest in the state. Some neighbourhoods have unemployment rates of over 30%. Unemployment is highest among young African-American males. (Baltimore City, Maryland, Brief Economic Facts)

Another negative outcome of poverty is **infant deaths.** Baltimore has the highest number of infant deaths per live births in the state of Maryland. For the period between 1991-1995 Baltimore had 13.7 infant deaths per 1,000 live births while the state-wide average was 9.3.

Baltimore is home to the largest number of **Medical Assistance recipients** of any of Maryland's political jurisdictions. Medical Assistance (MA) is a federal program providing health and mental health benefits. Eligibility is determined by an individual qualifying for one of several entitlement programs for poor and/or disabled individuals. The two most frequent entitlement programs are the Temporary Cash Assistance (TCA) or the Supplemental Security Income (SSI) program. TCA is for single mothers and their children while the SSI program is primarily for disabled adults who have not worked enough to qualify for federal programs such as Social Security or Social Security Disability Income (SSDI). In 1995 there were 187,346 Baltimore City residents on the Medicaid program which is 27% of the City's population and 40% of the number of MA enrolees state-wide.

Baltimore is also home to the greatest concentration of **homeless persons** and individuals in need of substance abuse treatment in the state. According to Action for the Homeless, a state-wide advocacy group, 50% of homeless individuals seeking shelter were from

Baltimore City. Baltimore Substance Abuse System, Inc. (BSAS) the manager of the city's substance abuse system, estimates that, in 1996, 59,822 or 12% of the City's 15-65 year old population was in need of substance abuse treatment and that 16,342 (27.3%) of these individuals in need received substance abuse treatment.

2. MENTAL HEALTH SERVICES IN BALTIMORE

Baltimore Mental Health Systems [BMHS] was created by the Baltimore City Health Department (BCHD) in 1986, pursuant to a grant from the Robert Wood Johnson Foundation, and it serves as the local mental health authority for Baltimore City. In fulfilling its mission to develop a co-ordinated network of care for adults who have serious and persistent mental illnesses and children with serious emotional disturbances, BMHS faced a number of governance and policy issues.

Public mental health services for Baltimore residents are funded by various sources. The two primary sources are Medicaid dollars and State general funds administered by the Mental Hygiene Administration. In the year ending June 30, 1997, BMHS managed $32 million in state and federal grants that funded a range of outpatient services which generated an additional $20 million in fees through billing Medicaid, Medicare (a federal insurance program for the elderly and disabled), insurance companies, and client payments. Last year, the system provided outpatient services to 16,282 individuals. The demographics of the individuals receiving services are: 63% African American, 30% Caucasians with the majority of the rest Asian or Hispanic individuals, and 53% of the individuals are male. Over 50% of the individuals have a major mental illness that includes a diagnosis of schizophrenic disorder, major affective disorder, or other psychotic disorder. About 65% of the individuals live with family members or other unrelated individuals. An estimated 60% of the individuals with a major mental illness have experienced multiple hospitalisations, usually in a state hospital, while an estimated 10% have been incarcerated one or more times for minor offences. Two out of three persons hospitalised in a state hospital are male. About 85% of the individuals with a major mental illness receive

Medicaid for health insurance and receive SSI or SSDI as an income entitlement due to their disability. (Agus, Blum, and Baron, pg. 263).

2.1 Managed Care

The funding and organisation of public mental health services in Maryland changed on July 1, 1997. Based on approval from the federal government, the state of Maryland is placing the majority of individuals on Medicaid in managed care. Until that time the individual's medical and psychiatric care was not managed and the individual had the choice to see any provider who was authorised by Medicaid to provide the service. In the new system, the recipients will have a medical home within a Managed Care Organisation (MCO). The MCO is responsible for providing all somatic care including substance abuse treatment while mental health services are carved out of this system. The Mental Hygiene Administration (MHA), the state mental health authority, was authorised to develop a Speciality Mental Health System. MHA's design has several components. They are:

(1) The system has contracted with a behavioural health organisation to serve as an **administrative services organisation (ASO).**

(2) The ASO will manage access to care and utilisation, pay claims, develop data from claims, and conduct evaluation.

(3) The system will be primarily fee-for-service and for the first time the mental health system will manage the dollars spent for inpatient care. In 1995 Medicaid spent $84 million on mental health care for Baltimore City residents of which $49 million or 58% was spent on inpatient care.

BMHS as the Core Service Agency for the city of Baltimore will enter into an agreement with the ASO to manage the system. There are several issues that will emerge in the first few years of the new design. They include:

- Whether there is a role for BMHS as a strong local mental health authority in the new fee-for-service in which approximately 85% of the dollars will be paid through fee-for-service.

- Whether BMHS will be able to design initiatives that target the most in need, i.e.,

an expansion of a specially designed mental health capitation project; and,

- Whether BMHS's autonomy and expertise will be respected and supported by the state.

2.2 Creation of the local Mental Health Authority

Prior to 1988, the Baltimore City Health Department (BCHD) had responsibility for contracting for mental health services within the City's seven catchment areas (geographic service area). Within each catchment area mental health services were provided by a variety of programs including community mental health clinics, community rehabilitation programs (psycho-social) and residential programs. In addition, several of the areas had emergency room services, and mobile treatment programs. Although there was a commitment to providing services to individuals with serious mental illness, the services were mostly office based and often the community relinquished its responsibility for clinical care when an individual refused to keep an appointment, was hospitalised, incarcerated, or became homeless. Services were fragmented and driven by programmatic and fiscal considerations rather than clients' needs. Further, there was no rationale for service development. Instead, historical determinism punctuated by crisis activated decisions and dictated policy. It was a perfect example of a non-system as described Dr. Leonard Stein:

> "a 'non-system' of mental health care, where a few patients get more than they need, many patients get less than they need, and some get nothing at all. Patients may get lost in this non-system, and no one feels obligated to look for them. Patients may refuse to follow a program's rules and be terminated from treatment by staff who believe that they had no other choice. Patients are moved from the community into the hospital and from the hospital back into the community such that the hospital, the community, the patient, and the family all feel mistreated. A major problem with this non-system is that it is episode-oriented rather than oriented to provide continuous care." (Stein, Diamond, Vol.5).

The purpose of the "Robert Wood Johnson Foundation (RWJ) Program on Chronic Mental Illness" grant to Baltimore City in 1986 was to enable Baltimore along with eight other

large urban areas to develop a co-ordinated system of care for individuals with serious and persistent mental illnesses. RWJ is the largest health care private foundation in the United States and this project was its first large scale mental health initiative. The City's application to RWJ articulated a need for a local mental health authority to develop a coordinated and comprehensive network of services responsive to the needs of the clients. The City's proposal stated that it would establish a local mental health authority with administrative, clinical, and fiscal authority for the adult mental health system.

The authority would be a public non-profit entity, outside of government, while still maintaining an accountability to government. It would be responsible for co-ordinating services to create a comprehensive network of community-based care. The authority would focus on expanding the range of services, improving continuity of care, developing new affordable housing opportunities, creating new financing initiatives, and promoting community acceptance and public education.

Upon receiving the grant, the City established BMHS as the local mental health authority for Baltimore City. It operates through a Board of Directors comprised of government officials, community leaders, and primary and secondary consumers of mental health services. BMHS has been responsible for distributing funds to service providers, re-designing the structure for the system of delivering and financing services, creating new services, monitoring quality of care, promoting continuity of care, establishing a computerised Client Information System, and developing affordable housing. BMHS envisions a co-ordinated network of services controlled by a strong, centralised local mental health authority which is responsive and accountable to the varying demands of the individuals it serves. Within this mandate the goals of BMHS are to:

- provide quality care;
- ensure continuity of care; and
- use scarce resources efficiently.

Over the past 10 years, BMHS has made major strides in accomplishing these goals. BMHS has:

- redesigned the delivery system by consolidating providers into Lead Agencies
- expanded the range of services to include mobile outreach, and services to homeless individuals with mental illness
- increased case management services
- increased linkages between state hospitals and outpatient providers to improve continuity of care
- created affordable housing through its non-profit housing development corporation, Community Housing Associates, Inc.
- established Baltimore Crisis Response, Inc. to co-ordinate and provide a full range of crisis services
- established an employment training program for primary consumers to be employed within the mental health system
- developed a major capitated financing demonstration to better integrate fiscal incentives with good care.

3. CHOICES IN CREATING A LOCAL MENTAL HEALTH AUTHORITY

Many of the decisions made in determining the design to be used in Baltimore are fundamental to creating a service delivery system anywhere. The difference in local condition might affect the ultimate decision, but the issues and choices are universal. The following describes several of these broad issues, the rationale for choosing a particular design option, and the impact of that design on system of care in Baltimore.

3.1 Whether to Provide Any Direct Services

Authorities or regulators face this dilemma: Is it best to control services by providing them, by having others provide them, or by a combination of the above?

The **mixed role**, of regulator and provider, presents certain advantages:

large urban areas to develop a co-ordinated system of care for individuals with serious and persistent mental illnesses. RWJ is the largest health care private foundation in the United States and this project was its first large scale mental health initiative. The City's application to RWJ articulated a need for a local mental health authority to develop a coordinated and comprehensive network of services responsive to the needs of the clients. The City's proposal stated that it would establish a local mental health authority with administrative, clinical, and fiscal authority for the adult mental health system.

The authority would be a public non-profit entity, outside of government, while still maintaining an accountability to government. It would be responsible for co-ordinating services to create a comprehensive network of community-based care. The authority would focus on expanding the range of services, improving continuity of care, developing new affordable housing opportunities, creating new financing initiatives, and promoting community acceptance and public education.

Upon receiving the grant, the City established BMHS as the local mental health authority for Baltimore City. It operates through a Board of Directors comprised of government officials, community leaders, and primary and secondary consumers of mental health services. BMHS has been responsible for distributing funds to service providers, re-designing the structure for the system of delivering and financing services, creating new services, monitoring quality of care, promoting continuity of care, establishing a computerised Client Information System, and developing affordable housing. BMHS envisions a co-ordinated network of services controlled by a strong, centralised local mental health authority which is responsive and accountable to the varying demands of the individuals it serves. Within this mandate the goals of BMHS are to:

- provide quality care;
- ensure continuity of care; and
- use scarce resources efficiently.

Over the past 10 years, BMHS has made major strides in accomplishing these goals. BMHS has:

- redesigned the delivery system by consolidating providers into Lead Agencies
- expanded the range of services to include mobile outreach, and services to homeless individuals with mental illness
- increased case management services
- increased linkages between state hospitals and outpatient providers to improve continuity of care
- created affordable housing through its non-profit housing development corporation, Community Housing Associates, Inc.
- established Baltimore Crisis Response, Inc. to co-ordinate and provide a full range of crisis services
- established an employment training program for primary consumers to be employed within the mental health system
- developed a major capitated financing demonstration to better integrate fiscal incentives with good care.

3. CHOICES IN CREATING A LOCAL MENTAL HEALTH AUTHORITY

Many of the decisions made in determining the design to be used in Baltimore are fundamental to creating a service delivery system anywhere. The difference in local condition might affect the ultimate decision, but the issues and choices are universal. The following describes several of these broad issues, the rationale for choosing a particular design option, and the impact of that design on system of care in Baltimore.

3.1 Whether to Provide Any Direct Services

Authorities or regulators face this dilemma: Is it best to control services by providing them, by having others provide them, or by a combination of the above?

The **mixed role**, of regulator and provider, presents certain advantages:

First, there is greater control both in terms of defining a service and fitting it into a cohesive, clinical network.

Second, it is easier to co-ordinate, to provide consistency and to adapt more quickly a particular service to needs. By combining the management and policy setting roles with direct service, one enjoys a stronger linkage and, maybe, a quicker response time between systemic needs and priorities, and the services provided.

BMHS nonetheless chose **not** to be a direct service provider for the following reasons:

First, if one is both a provider and a regulator/payer there is a confusion of roles with a strong potential for conflict of interest in areas of quality assurance, redefinition of services, and allocation of new funds for services (Stein and Diamond Vol. 5).

Second, as a competitor with other providers, yet with authority for managing the system, there might be a perception of inequality or favouritism, causing the decisions of BMHS to be viewed suspiciously or sceptically. BMHS would have difficulty acting as an arbiter and manager, as an authority, when instead of being above the fray it was in the middle of it. Therefore, BMHS determined that it was unwise to compromise itself by providing services.

Although this issue was resolved early in the development of BMHS, it has arisen again from time to time as new services develop, and the temptation to take a more active role persists. For example, after investing much time and resources on developing a model for a new crisis system, there was some feeling that the new centralised crisis centre should be under the direct control of BMHS. Members of BMHS board of directors felt it was "our" baby and we should ensure that it fulfilled its promise and adhered to specific principles by directly operating the service. However, although the new role was enticing, after re-examining the original rationale for avoiding direct services, the BMHS Board reaffirmed its role and established an independent crisis system provider which BMHS monitors through its contract with the provider. Understanding why one is making a decision and examining the short and long-term ramifications within a framework, clarifies the issue and facilitates reasoned decision-making.

3.2 Centralisation vs Decentralisation of Services

Baltimore City, as noted earlier, is divided into 7 catchment areas each of which had an

existing array of services when BMHS started. BMHS considered options ranging from the one extreme of centralising all services to the other, of centralising no services and having a multitude of separate providers for each service. The middle ground options, were to have either the regional services or to centralise only certain specialised services.

BMHS decided that **the core services should exist in each area** but should be consolidated under the auspices of one strong area authority: the Lead Agency. Decisions on specialised services would be made on a case by case basis. Consolidating the providers under the Lead Agency umbrella reflects both the desire to emphasise the comprehensive needs of individual clients rather than strengthening individual programs into which clients then need to fit, and the desire to create a strong constituency at the direct service, or local level. Theoretically, we have retained the strong neighbourhood affiliation and enhanced the accountability of the providers by combining them within a Lead Agency whose mission is to serve all clients, and all needs, regardless of affiliation with a specific provider/program or lack thereof. Each Lead Agency is then a part of the larger co-ordinated system of care under the aegis of BMHS.

Thus, at the direct service level, services are decentralised by being controlled and consolidated at the local level within the Lead Agency, while decisions on planning, management and funding are centralised under BMHS. As new specialised services are developed, BMHS analyses the benefits of centralising or decentralising that service, balancing systemic needs with the role of the Lead Agencies and neighbourhood needs. For example, in the realm of services to homeless persons, a recent discussion centred on the issue of whether to create a specialised city-wide provider for mental health services to homeless persons, or to continue to encourage/require the Lead Agencies to reach out and integrate homeless individuals into their programs.

The benefits of centralisation relate to control, speed, and direction: one provider with a clearly defined mission can act more quickly and definitively to serve its specifically targeted population. Additionally, since people who are "homeless" by definition do not actually reside in a catchment area, it was argued that services should not be catchment area

based. The benefits of decentralisation are those of long term integration, accountability of Lead Agencies for comprehensive services and the best use of available resources for the entire system within which homeless services are a part. BMHS believes that people who are homeless and mentally ill resemble the majority of the target population for outpatient services once they are housed: homelessness is at times a consequence of the mental illness and in any event is not, and should not be treated as, a permanent condition. Using the framework of the Lead Agency system as a focal point for decision-making, and applying and examining the benefits, and concomitant disadvantages, described above, BMHS determined that homeless services should remain with the Lead Agencies. Attention has focused on strengthening the Lead Agencies' commitment to, and accountability for, this population without creating a new, separate, service. This decision is opposite to that made for crisis services where different elements, e.g. the acute and specialised nature of the services, prevailed, outweighing the arguments for decentralisation. Similarly, in providing services to children and adolescents, we have determined that the best approach to delivering services to "high end" children and adolescents is the establishment of a city-wide service.

3.3 Division of Power: Intrusive vs Guided Management

A central authority with clearly articulated goals, and without direct-service responsibility, must determine whether the best way to achieve these goals is through direct intervention in the interstices of a service provider's business or by macro-management through specified goals and outcome criteria. These options are easily understood with reference to the clinical or financial arena. For example, a mental health authority has the option either to monitor and approve a very specific budget and all modifications thereto, or to allow budget flexibility as long as the outcome criteria, such as improved client functioning in vocational areas, are met. Similarly, the authority might choose either to mandate specific numbers of units of services which must be provided to each client, or instead use an outcome measure such as quality of life indicators. There is of course, as in each decision, a full spectrum of alternatives from which the authority might choose, and additionally it can mix and match, i.e., flexibility in clinical issues but strict controls in financial areas.

There are also limitations to flexibility imposed by external factors such as State law, and by internal factors such as the ability of the authority to perform quality assurance reviews measuring subtle indicators.

BMHS is taking an evolutionary approach: the goal is towards increased flexibility but the reality is that we are reaching this incrementally as we educate ourselves, our providers, and the State. In spite of its commitment to this principle, day-to-day issues tempt BMHS with micro-management and we struggle to sort out which decisions to make and how involved we should be. Flexibility is risky but the potential benefits of greater creativity and empowerment of consumers and providers to respond to individual needs, justifies the risk. Other authorities might determine that the safety of greater control outweighs the risk in their system.

The capitation demonstration developed by BMHS and supported by the state, and described in detail later in this paper, is designed to explore fully the potential of "guided management". The demonstration allows a good deal of flexibility and autonomy at the Lead Agency level in exchange for stringent quality assurance and articulated outcome criteria contained in a negotiated contract.

4. SYSTEM REDESIGN: LEAD AGENCY

One of the first tasks of BMHS was redesigning the service delivery system to create **Lead Agencies**. BMHS organised individual service providers in each catchment area into a Lead Agency, whose overall mission is to reach out to persons in their area with chronic mental illness regardless of whether they are a "client" of any one of the existing programs. The design has been built on the principle that providers as a group must shed their programmatic territorialism and consider the "whole" client rather than pigeonholing clients within programmatic barriers.

Each Lead Agency is headed either by the Chairman of the Department of Psychiatry, in the 5 hospital based agencies, or by the Executive Director of the free-standing corporation

in the remaining two areas. There is a Lead Agency governing consortium comprised of the heads of each service component. Contracts between BMHS and the Lead Agency describe the structure of the Agency and delineate both the Lead Agencies' and BMHS' responsibilities. Therefore at the provider level, services are decentralised, controlled at the community level, and consolidated within one local agency. However, decisions on planning, priorities, management, and funding are centralised under the aegis of BMHS.

The Lead Agencies grapple with issues of co-ordinating care and respond to clinical and planning issues raised by BMHS. The Lead Agency directors meet as a group with the President of BMHS to discuss system-wide issues and concerns. It is BMHS' expectation that local input, derived from client-centred service providers, will drive the planning of future systems.

This network of care reflects an "adaptation to local conditions", such as the pre-existing neighbourhood-based catchment area system and the presence of several large general hospitals with hospital-based community psychiatry programs. One such hospital is the University of Maryland Medical Systems, (UMMS) whose Department of Psychiatry was designated as a Lead Agency in 1993.

UMMS provides mental health services to the 160,000 residents of South and Southwest Baltimore. In this capacity, the UMMS Lead Agency develops, provides, and evaluates community mental health services to persons with serious mental illnesses and children with serious emotional disturbances. The Department of Psychiatry has a long history of academic excellence and commitment to community services. Chaired by Dr. John A. Talbott, former president of the American Psychiatric Association and long-standing editor of Psychiatric Services (formerly Hospital & Community Psychiatry), the Department has emphasised state-of-the-art administrative and community-based services. Of the more than 1900 active adult patients served by the UMMS Lead Agency last year, more than 40% (790 patients) have a diagnosis of schizophrenia. The patient population demographically closely reflects the urban Baltimore community with 64% African American, 35% Caucasian, and less than 1% other races. Services within the UMMS Lead Agency closely

parallel the ideal community support system described by the Community Support Program of National Institute of Mental Health (NIMH) (Stroul, 1989). They include outpatient mental health and addiction services, psychosocial rehabilitation, vocational services, housing, entitlements, health and dental care, crisis response services, and assertive community treatment. Consumer and family involvement are strongly supported. These programs make up a continuum of care critical to successful outcomes for persons with severe mental illnesses.

The UMMS Lead Agency has a continuum of treatment services with three levels of care. Approximately 20% of the individuals with Serious and Persistent Mental Illness (SPMI) receive services in specialised high intensity teams modelled closely after the Program in Assertive Community Treatment (PACT Team) program. The PACT clients typically have had multiple psychiatric hospitalisations and high use of emergency room services with poor outpatient compliance. Non-medical PACT staff (social workers, case managers, consumer staff) have a caseload of approximately 12 clients, and the staff: patient ratio for PACT psychiatrists in 1:75. The UMMS PACT team has a specific mission to include homeless adults with severe mental illnesses in Baltimore and includes consumer advocates to facilitate outreach and engagement of this disaffiliated subgroup. These consumer advocates are paid staff members who have a history of homelessness and/or mental illness. They do not carry a caseload, but assist patients in meeting their treatment goals. They are often instrumental in engaging patients and in locating patients who drop out of contact provide peer counselling, and serve as role models for patients. The importance of consumer participation and its challenges have been documented in "Consumers as Service Providers: The Promise and Challenge" (Dixon, Krauss, and Lehman, 1994. This article was selected by the World Psychiatric Association in its 1995 volume "Advances in Psychiatric Knowledge").

An additional 20% of Lead Agency patients are served in a mid-level intensity team with higher consumer/staff ratios but still embraces many key PACT elements (Continuous Care Team (CCT)). Non-medical CCT staff have a caseload of approximately 25 clients, and the staff: patient ratio for CCT psychiatrists is 1:100. In the UMMS Lead Agency the two

speciality teams, PACT and CCT, differ in ways outlined below, yet each provides mobile, interdisciplinary, comprehensive, 24-hour, continuous (inpatient/outpatient) care with a one stop shop approach. In addition, the teams employ a full-time family outreach worker who is a family member of a consumer. This person participates with the teams in treatment planning and provides support and education for family members. S/he assists with the planning and conducting of family meetings and runs family group interventions as described by McFarlane, et al (1991). The current population served on the two teams consists of 44% women and 64% African-Americans. Sixty-five percent of the individuals served have a diagnosis of a schizophrenic disorder.

The remaining 60% of the SPMI population is served within two outpatient clinics with adjunctive case management available. The non-medical therapists in the clinics have case ratios of 1:65 while a full-time psychiatrist has a caseload of 1:200. Very little off-site care is provided and when hospitalisation is necessary, care is co-ordinated via phone contact between in-patient and community providers.

Because of the high prevalence of persons with co-occurring addictive and mental disorders, each team and clinic provides integrated substance abuse treatment services with individual and group interventions. Crisis services for individuals receiving care within the Lead Agency are provided by the speciality teams through on-call coverage, while patients served in the outpatient clinics can receive immediate, 24-hour response and intervention to crises within a hospital-based psychiatric urgent care system. This includes the capacity for brief intensive care management until the person can be engaged in other Lead Agency programs in the City. The Lead Agency has a close working relationship with Baltimore Crisis Response, Inc. (BCRI) which provides crisis services for individuals in need of mobile crisis and crisis residential services.

Community-based member-driven psychiatric rehabilitation services for individuals with severe mental illnesses are provided at Harbor City Unlimited, an UMMS Lead Agency operated program. This includes a strong vocational program and a structured day treatment program. In addition, Harbor City Unlimited manages a full continuum of

housing ranging from 24 hour staffed group homes to supported housing services.

Assignment of a patient to a level of care is based upon the client's score on the Multnomah Community Assessment Scale, the Substance Abuse Treatment Scale (SATS), and clinical judgement. The CAS is a 17-item instrument designed to be completed by case managers and gives a measure of the patient's severity of disability. It was originally developed for persons with chronic and severe mental illnesses and is administered at the UMMS Lead Agency programs during baseline evaluation and every three months thereafter. This instrument is used to rate the client on ability to structure daily activities, social effectiveness, treatment compliance, frequency of crises and other dimensions which assist in determining the intensity of outpatient treatment needed as well as providing outcome data on key dimensions. The UMMS Lead Agency has modified the Alcohol/Drug Abuse item on the CAS to be the five-point clinician alcohol/drug use scale (CRS) developed by Drake, Osher, & Wallach (1989). The CRS corresponds to DSM-III-R criteria, has been shown to be reliable, sensitive, and specific when used by case managers, and does not change the overall CAS score. Patients scoring between 20-50 on the CAS are typically assigned to the PACT team, between 35-65 to the CCT, and between 50-80 to the outpatient clinics. The SATS (McHugo et al 1995), used with persons who are dually diagnosed, combines a motivational hierarchy with explicit substance use criteria to form an eight-stage scale of the recovery process. The SATS is used as both an assessment instrument and outcome measure. The UMMS Lead Agency provides ongoing training to case managers on the use of these measures. Referrals to level of care go through a single evaluator and monthly meetings of all Lead Agency Medical and Program Directors address case assignment issues. For services not directly provided within the UMMS Lead Agency (i.e., inpatient care at the Carter Center, a state operated acute inpatient care facility, supported employment at the Schapiro Training and Employment Program, a city-wide supported employment program, and BCRI) interagency agreements have been developed.

5. EXPANDING AND CREATING SERVICES IN RESPONSE TO SYSTEM-WIDE NEED

This focus on systemic issues did not prevent BMHS from concomitantly expanding and restructuring services. To the contrary, consistent with the principles enunciated above, BMHS has developed services, and programs, as described below, which have had a profound impact on the treatment of individuals with severe and persistent mental illness.

5.1 Expansion of the Range of Services

For the past ten years, BMHS has focused on increasing mobile services particularly to individuals not well served by the mental health system. BMHS has established a Case Management Unit (CMU) within each Lead Agency and has provided resources to allow each CMU to hire staff to provide intensive, brokering case management services. There have been over 30 new case management positions created along with the development of the State of Maryland's first Medicaid funded mental health case management program. Through these resources the mental health system has assumed responsibility for individuals who fail to keep appointments and who reject traditional mental health services. The following vignette describes an individual who is typical of many of the individuals receiving case management services:

> "Mr. C is a 39 year old male with Schizophrenia Chronic Undifferentiated Type. Since the age of 8, Mr. C has spent most of his life in institutions. Over the past twenty years, his life has been grossly disorganised. He has had numerous arrests for disturbing the peace, urinating in public, loitering, and attempting to direct traffic. Before his involvement with the Case Management Program, he had not remained in the community longer than five consecutive months. He was almost always homeless, had extremely poor hygiene, and wore unseasonal attire.
>
> Mr. C was assigned a case manager and his case manager began working with him on what would prove to be a long and challenging endeavour toward keeping him out of the hospital and engaged in out-patient treatment.
>
> Initially, his case manager accompanied Mr. C. to all appointments while working to develop a rapport based on support and mutual trust. Eventually she discontinued escorting him to the clinic and began calling transportation for him,

each time phoning both the client and the bus services more than once to ensure follow-through. After a couple months of having transportation arranged for him, he began to use the phone to call transportation himself. Slowly, he learned how to call for appointments and even to reschedule missed appointments.

The past year has brought many positive changes for Mr. C. He was fitted for dentures. He paid back in full a Baltimore Mental Health Systems (BMHS) loan which was provided for his dental care. Mr. C connected with his family, and together they have moved into a brand new fully furnished three bedroom apartment with central heat and air, washer and dryer, and dishwasher available through BMHS 's housing subsidiary Community Housing Associates (CHA). He is currently paying on his second BMHS loan approved for the payment of the security deposit on his new home. He reports living the life he has wanted for many years but needed support and encouragement to attain."

BMHS has prioritised expanding services to individuals who have a serious mental illness and are homeless. Through BMHS's efforts, services to the homeless mentally ill have been expanded in Lead Agencies in five of the City's seven catchment areas. In addition, BMHS was a successful applicant for a three year, three million dollar NIMH grant which established the assertive community treatment team at UMMS, has been a partner in the Office of Homeless Services successful federal applications that has created assertive community treatment teams for two additional Lead Agencies, and has been a co-sponsor with the local and state housing authority for grants to support affordable housing for homeless mentally ill individuals.

5.2 Crisis Care

The backbone of a good community based mental health system is the presence of an emergency system which is comprehensive, well co-ordinated, and committed to providing a range of community alternatives. (Stein and Diamond, Vol. 5) In its role as the manager

of the system, BMHS convened a task force that met for a year and developed a plan to redesign the psychiatric crisis system. The report called for the creation of a new entity to operate mobile crisis services, to manage crisis residential alternatives, to provide information and referral services, to have authority over pre-admission screening, and to co-ordinate the emergency services provided by the emergency rooms and community mental health clinics of the Lead Agencies. This plan established Baltimore Crisis Response Inc.

Baltimore Crisis Response, Inc. (BCRI) is a community-based crisis intervention program. The mission of the agency is to assist adults experiencing mental health crises by providing timely, effective, crisis services in the most therapeutic and least restrictive environment possible. Specifically, the goal is to treat people in the community and prevent unnecessary inpatient admissions to psychiatric hospitals. BCRI, which began operating May, 1993, provides three clinical services to the community. These services are:

i. **Information, Referral, Crisis Hotline**: The hotline is available to the metropolitan Baltimore area and operates 24 hours a day, seven days a week. The hotline provides crisis counselling, suicide prevention, and community referrals. The hotline operates as the gateway to the Mobile Crisis Team and receives about 10,000 calls annually.

ii. **Mobile Crisis Team**: The Mobile Crisis Team (MCT) (including a psychiatrist, nurse, mental health counsellor and case associate) is dispatched in Baltimore City. The team operates from 8am-11pm, responds to people in crisis in their homes, shelters, hospitals, and other community locations. The MCT assesses the person in crisis, initiates interventions (crisis counselling, starts medications), and makes linkages to mental health services and other community resources. A psychiatrist and mental health professional are available 24 hours a day, seven days a week.

iii **Crisis Residential Alternatives**: The crisis residential intervention includes in-home support or crisis beds and operates as an alternative to inpatient hospitalisation. In the event that the person needs additional support in home, BCRI can provide in-home mental health counsellors. The counsellors can stay in the person's home up to 48

hours, assist in transporting the person to appointments, monitor medications and provide emotional and behavioural support. This service can be provided for 48 hours around the clock or in increments (i.e. for five hours-a-day up to eight days). If the person does not have a supportive home environment, BCRI also operates crisis beds. The crisis beds are supervised 24 hours a day. Services include daily counselling, medication monitoring, linkages to community services, and daily transportation to health and mental health appointments for up to five days. The goal is for the person to be clinically stabilised and linked to appropriate community resources prior to discharge.

5.3 Improvements In Continuity of Care

The community frequently relinquishes its responsibility for clinical care when an individual is hospitalised, incarcerated, or becomes homeless. BMHS's Lead Agency agreements require each Lead Agency to assume responsibility for individuals regardless of where they are living. BMHS also established a project to improve continuity of care for individuals being discharged from State Hospitals known as the Service Area Co-ordinator initiative. The project has as its central concept the designation of responsibility to a Lead Agency for each patient being discharged from a state hospital. BMHS staff are responsible for linking patients to Lead Agencies by referring them to the Case Management Unit of the appropriate Lead Agency. This process not only improves continuity of care, it encourages the hospital and community to work together with the patient to create an individualised plan for community living.

Case managers from the Lead Agency are charged in all cases with the responsibility of developing and carrying through an individualised plan for the patient's return to the community. The Lead Agencies depend on their Case Management Units (CMU) to provide services to individuals wherever the persons may be living. It has not been unusual for the CMU staff to work with a client six months prior to his leaving the state hospital, or to develop housing opportunities for an individual whom they met in a homeless shelter.

An important element of continuity of care is the availability of information which allows for client tracking and system utilisation reviews. BMHS has developed a Client

Information System (CIS) based on a unique identifier which compiles demographic and utilisation information on individuals seen in the public outpatient system and discharged from a state hospital. The CIS has developed reports which identify multiple users of emergency rooms and state hospitals who have not been seen by the community mental health clinics. Attempts have been made to target these individuals for intensive case management services.

5.4 Creation of Community Housing Associates to Develop Housing

Community Housing Associates, Inc. (CHA) is a non-profit organisation whose primary mission is the development of affordable housing in Baltimore City for persons with mental illness. CHA is a subsidiary of Baltimore Mental Health Systems, Inc. (BMHS), and was established in 1989. Through its close relationship with BMHS, CHA ensures that tenants have access to mental health services.

CHA has developed 400 units of housing for persons with mental illness through a variety of funding strategies, which include use of State loan and grants, federal government assistance, funds from the Robert Wood Johnson Foundation and federal tax credits. Also CHA manages 200 Section 8 certificates and 190 Shelter Plus Care sponsor-based rental assistance beds. Section 8 is a federal program that provides housing assistance to poor individuals in which the tenant only pays about 30% of their income towards rent. Shelter Plus Care is another federal program and closely resembles Section 8 except that it is restricted to disabled individuals who are homeless. Some of the rental subsidies are used to operate CHA-owned housing and the rest are used to lease units from private owners. CHA's housing activities are co-ordinated with BMHS-funded mental health providers and tenants are able to access housing in any area of Baltimore City.

Access to CHA housing is limited to low-income people who have a history of mental illness. There is no requirement for participation in programs or services as tenants sign a lease and they only way they can lose their housing is if they choose to move elsewhere or break their lease. The following is a description of a resident of CHA's housing:

"PA is a 35 year old female with a new-born baby and two other children. PA has a diagnosis of Schizophrenia Chronic Undifferentiated Type. She has been receiving treatment in a community mental health clinic of a Lead Agency. PA was referred to Community Housing Associates (CHA) by a case manager.

PA's initial interview for CHA's housing was conducted at a shelter for the homeless in East Baltimore. PA was 7 months pregnant at the time and very concerned about finding housing before she had the baby. PA's son and daughter had been placed in foster care until she could provide stable housing for them. According to the foster care worker, homelessness was the primary reason PA's children were in foster care.

PA's goal was to rent a 3 bedroom apartment or house at an affordable price so that she could reunite her family. CHA was able to place PA in a 3 bedroom house, while also providing furniture in the living room and dining areas, as well as kitchen utensils (i.e. dishes, pots, and pans). Baltimore Mental Health Systems provided a no-interest loan to PA to purchase bedroom furniture. PA pays 30% of her income for rent and utilities.

Due to her demonstrated stability, PA's children were returned to her over three years ago. PA and her children continue to reside in CHA housing."

5.5 Development of Capitation Demonstration Project Integrating Clinical and Fiscal Structures

Persons with schizophrenia and other major mental illnesses require a comprehensive, diverse and ever-changing range of services over a long period of time. Moreover, because of the complex and chronic, yet episodic, nature of the disease, each client presents different needs over time. However, traditional financing is fragmented, relatively inflexible, and program specific. Furthermore, the incentives created by current financing often encourage providers to use less than optimal approaches to treatment. BMHS developed a planning process using a Capitation Work Group comprised of mental health financing specialists, and a representative from the state Mental Hygiene Administration and the State Medicaid Agency, which established the Capitation Demonstration Proposal to address this problem. Implementation of the Project started in the fall of 1994 with the hiring of staff and training and the first client enrolled in May 1995.

The purpose of the demonstration is to reconfigure the financing system to facilitate high quality, comprehensive care to clients in the community with individualised, flexible and innovative treatment plans. Specific goals are:

- To increase the accessibility of services to those who often face barriers.
- To increase the continuum of services, including services that are useful but not easily paid for under current funding.
- To reduce the use of expensive general hospital bed days and enrich community services accordingly.
- To develop fiscal integrity for the local system and increase ability to plan for the future.
- To provide predictable costs for funders while encouraging creative and entrepreneurial activity, with retention of savings in carry-over funds.

The design of the Project is as follows:

- There will be 300 clients enrolled in one of two capitation Lead Agencies. The Lead Agencies were chosen pursuant to a competitive Request for Proposals open to all seven Lead Agencies.
- The 300 clients will be persons who are diagnosed with a severe and persistent mental illness and who are currently in a state hospital or who have been discharged from a state or general hospital within the past two years. At least 1/3 will be current state hospital residents who have been hospitalised for at least 6 months.
- The state transfers to BMHS a lump sum payment comprised of Medicaid dollars and state grant dollars previously used to fund state hospitals and community services.
- BMHS takes money off the top for administration purposes (3.5% of rate) and to place into an incentive account (1.5%) and a risk pool (2.0%).
- BMHS then pays, quarterly, the remainder of the capitated rate to the Lead Agency multiplied by the number of enrolees.
- With this payment, the Lead Agencies are required, by contract, to pay for all of the enrolee's mental health needs including inpatient hospitalisation. They are also required to provide for meeting other needs such as health, dental, housing and substance abuse treatment and are allowed to use capitation funds for these purposes as necessary. They are also allowed to use these funds in other creative ways to pay for items or services that are non-traditional but necessary for the client's success.

- BMHS monitors services throughout the year using threshold criteria and face to face meetings, and then contracts for an annual independent evaluation.

- The CLA's are evaluated according to outcome criteria reflecting a client's quality of life. These outcome criteria include positive indicators such as employment and independent housing, as well as systems indicators such as hospitalisation and jail time which BMHS wants to reduce.

- Pursuant to the evaluation, each Agency receives a grade which determines whether the Agency will receive funds from the incentive account and whether they will be able to retain up to 85% of their unspent funds. Thus, monetary incentives are directly related to quality of care.

- The unspent funds returned to BMHS are apportioned between the Risk Pool and a Development Account for new services thus spreading risk and savings across the system.

- Finally, and most importantly, BMHS is responsible for providing leadership and vision and translating that into action through an ongoing training program.

After 3 years, there are 163 clients currently enrolled, 120 of whom had been in a state hospital at least 6 months in their last stay. The average length of last stay is seven years. The following story illustrates the benefits of the Project.

> "Mr. Brown was hospitalised for nine continuous years before leaving Springfield State Hospital, a Maryland State Hospital, in June, 1994. His goals were "to find a job, open a bank account, and to have my own apartment." Mr. Brown has been working twenty hours per week in a second-hand store for three years. He is presently looking for a full-time job. He enjoys buying clothes and items for his apartment with the money he saves from each paycheck. This September, Mr. Brown plans to renew his apartment lease for the third year. According to his sister, "We were told by doctors in the hospital that my brother couldn't live in the community. Now he has his own apartment, he's got a job. We're so proud of him."

Like the benefits, the challenges involved in implementing this Project are numerous. First, the clients have exhibited a very high degree of serious, physical illness resulting in a higher than expected mortality rate (11 deaths) and a great deal of time and effort spent in improving linkages to health care. Second, when greater flexibility and risk-taking are encouraged, it is constantly necessary to balance reasonable risk with high support and prudent oversight. There are also many issues related to housing such as safety,

affordability, cleanliness, client choice and whether to enforce minimum guidelines.

Yet, with all of these challenges, the Project has been quite successful. Both programs have created teams with social workers, nurses, psychiatrists and consumers who work together to meet the client's needs. The teams are empowered to use their skills and resources creatively to meet a client's needs. For example, one project has used some funds to create a job at a hospital for its clients by agreeing to pay part of the salary. All staff work at developing unique relationships and challenging themselves and their clients to reach their full potential.

Both programs received an "A" minus on last years evaluation while realising substantial savings. Plans are currently underway to use money in BMHS' Development Account for a joint project for job development. There will also be a joint endeavour to create some new resources for persons with mental illness and substance abuse diagnoses.

A unique feature of this model is its combination of mechanical innovations, the financing, and state-of-the art clinical approaches supported by training and by the focus on outcomes related to quality of life. In this Project, BMHS has fully realised the concept of guided management by focusing on goals rather than mandating specific services, processes or staffing patterns.

6. IMPLICATIONS FOR OTHER SYSTEMS

As described above, each decision on an element of management or governance leads to specific decisions on programmatic, fiscal and clinical issues. There are other decisions beyond those analysed above which can only be mentioned briefly, such as whether to restrict the number of providers, as BMHS did, or to encourage many unrelated and competing providers as the new MHA system design is doing. Other decisions will face us in the future and will be determined largely by reference to the initial principles and goals articulated by the framework of the system design.

As mental health authorities develop in other locales, the first task should be to determine values, set overriding goals and then develop the framework to meet these goals based on the general issues described in this paper. Then when specific issues arise they can be addressed coherently within this framework, rather than in an ad hoc, serendipitous manner.

BMHS has articulated the values of a flexible system of high-quality comprehensive services designed to meet the needs of all adults with severe and persistent mental illness and children, adolescents and their families with serious emotional disturbances. The system redesign and service initiatives reflect these values as will future decisions. The focus on long-term structural change rather than dramatic, rapid clinical service change is difficult to maintain but, we firmly believe, worthwhile. The results will be far-reaching, permanent and comprehensive.

REFERENCES

1. Stein, Leonard M.D., Diamond, Ronald M.D., Factor, Robert M.D., "A System Approach to the Care of Persons with Schizophrenia." Handbook of Schizophrenia, Vol. 5, Psychosocial Therapies, Elsevier Science Publishers, Amsterdam, the Netherlands.

2. H. Golman, J. Morrissey et al: "Lessons from the Program on Chronic Mental Illness." Health Affairs, Fall, 1992, 51-67.

3. Agus, Deborah, Blum, Stephen, and Baron, Stephen. 1995. "Building a Capitated Public Mental Health Service for Seriously Mentally Ill Adults: The Baltimore Experience." Administration and Policy in Mental Health. (22) 3. January, 261-271.

4. Barker, S., Barron, N., McFarland, and B.H. Bigelow, D. "A Community Ability Scale for Chronically Mentally Ill Consumers: Part I. Reliability and Validity." Community Mental Health Journal, 1994, 30, 363-383.

5. Dixon, L., Krauss, N., and Lehman, A. "Consumers as Service Providers: The Promise and Challenge." Community Mental Health Journal 1994, 30, 615-625.

6. Drake, R.E., Osher, F.C., and Wallach, M.A. "Alcohol Use and Abuse in Schizophrenia: A Prospective Community Study." Journal of Nervous and Mental Diseases 1989, 177, 404-414.

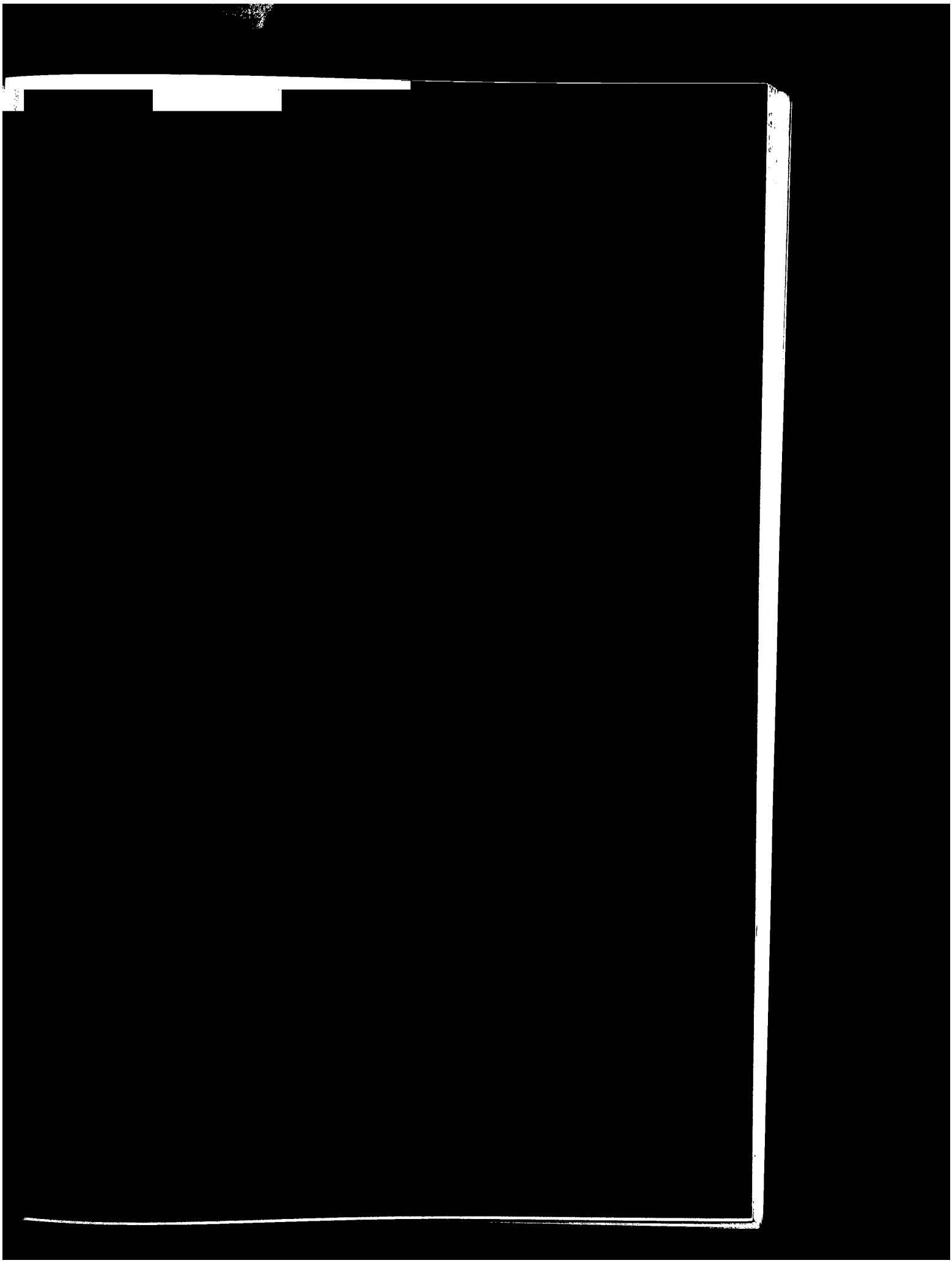
7. McFarlane, W.R., Lukens, E., Link, B., Dushay, R., Deakins, S.A., Newmark, M., Dunne, E.J., Horen, B., and Toran, J. "Multiple-family Groups and Psychoeducation in the Treatment of Schizophrenia." Archives of General Psychiatry 1995, 52, 679-687.

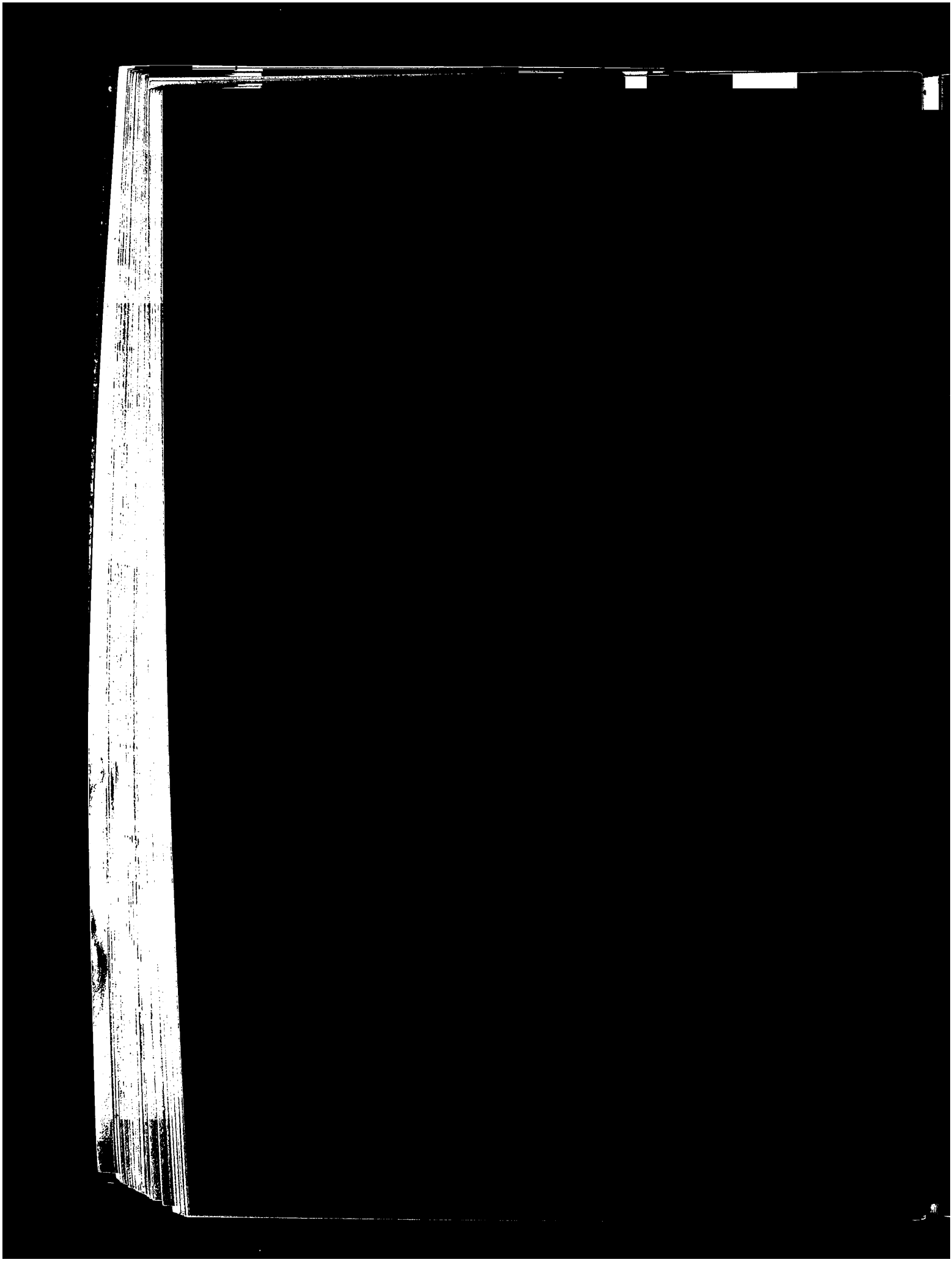
8. McHugo, G.J., Drake, R.E., Burton, H.L., and Ackerson, T.M. "A Scale for Assessing the Stage of Substance Abuse Treatment in Persons with Severe Mental Illness." Journal of Nervous and Mental Disease, 1995, 183, 762-767.

9. Stroul, B., Toward Community Support Systems for the Mentally Disabled: the NIMH Community Support Program. Boston: Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professions, 1984.

10. Baltimore: Past, Present and Future Trends and Projections.

11. Baltimore City, Maryland, Brief Economic Facts.





CHAPTER 3

THE CITY OF BANGALORE, INDIA

S Murthy

Professor S. Murthy
National Institute of Mental Health & Neuroscience
Post Bag 2900
Bangalore 560 029
India

Tel: 00 91 80 664 2121
Fax: 00 91 80 663 1830

CONTENTS

1 INTRODUCTION

Jawaharlal Nehru, the first Prime Minister of Independent India, named Bangalore the 'India's city of the future'. Bangalore is like no other city in India. It has a history of 460 years. Bangalore is the most westernised Indian city. It is also described as the most cosmopolitan Indian city. It is certainly the most youthful city in India. Bangalore symbolises the emerging India which is progressive and vibrant, and represents a country in transition. This transition in the city is reflected in the popular names for the city. Up until about two decades ago Bangalore was known as 'a pensioner's paradise', 'air-conditioned city', 'the garden city of India', and it is now more popularly known as the 'silicon valley of India'.

THE BANGALORE CITY

Area	:	366 square kilometres
Population	:	4,807,019 (1991 census)
Altitude	:	920 meters above sea level
Latitude	:	Latitudinal parallels 12° 8'N
		Longitudinal Meridians 77° 37'E
Climate	:	Salubrious and warm
		Warmest - April 33.4° to 21.2° C
		Coldest - January 25.7° to 15.3° C
Rainfall	:	Mean annual rainfall : 859.6 mm.
Languages widely spoken	:	Kannada, Tamil, Hindi and English
Major industries	:	Aeronautics, telecommunications, Electronics, Computer engineering, Computer software, Electrical, Machine tools, watch-making, breweries and distilleries, handicrafts, silk processing, garment export, granite and horticulture

---

2 THE CITY OF BANGALORE

2.1 History

Bangalore seems to have been an inhabited area from the first century AD. Roman coins have been found in Yeswanthpur and the present HAL area. The Bangalore area was ruled by the Gangas for six centuries till the 10th century AD when it came under the Yelahanka, feudatory to the Vijayanagar rulers, who built a mud fort around Bangalore in 1537 AD. Around 1637 Bangalore was conquered by the Bijapur sultans and Shahaji Bhonsale, father of Shivaji, was given Bangalore as a Jagir. After 50 years of Bijapur rule, Bangalore was captured by the Mughals who held it for three years. Following this the town came under Chikkadevaraja Wodeyar of Mysore (1673-1704) who built a second fort to the south of the one built by Kempegowda. I.Hyder Ali and Tippu sultan during their rule built the famous botanical gardens, Lalbagh, initially of 40 acres and currently over 100 acres. The cantonment area of the city developed as a self-contained township during the latter part of the 19th century, along with a rail linkage in the 1860's. During 1896-99, Sir Winston Churchill, who was a lieutenant in the 4th Hussars, lived in Bangalore city.

27 BC	Coins of Roman emperors found at Yeswanthpur.
850 AD	The name Bangalore occurs for the first time on a 9th century stone inscription.
1024	Part of Chola empire
1537	Kempegowda builds the town.
1638	Conquered by the Bijapur Army
1640-44	Maratha Rule
1687	Moghul rule.
1799	Wodeyar family of Mysore kingdom.
1809	British cantonment.
1831-81	British rule.
1881	Maharaja's rule.
1937	Mental Hospital, Bangalore.
1949	Bangalore Municipal corporation
1955	Modern state legislature - Vidhana Soudha built

1956	Capital of unified greater Mysore.
1961-71	Industrial townships of aeronautics, telecommunications, machine tools, watches, electrical equipment.
1980	Preferred location of computer hardware and software companies.

Independence brought radical changes in Mysore state. Mysore state became an integral part of India politically with the Maharaja losing his powers and making way for an elected government. The capital of the state was shifted from Mysore to Bangalore in 1956.

The growth of Bangalore in the last 4 decades has been phenomenal. The population of the city nearly doubled during the decades of 1941-51 and 1971-1981, with slight slowing during the 1981-91 period. Bangalore is unusual among the Indian cities in the sense that it is a centre for both hi-tech industries and advanced research in the sciences and technology. This happy mix of industry and research is a factor in its recent emergence as a world class centre for computer software design, and also a centre for foreign investment. "Some 160 computer companies, most of them working on overseas software contracts, are located in Bangalore" (Time, March 14, 1994).

2.2 Area

In 1961, there was a sudden and substantial increase in the area of Bangalore city. During the last 3 decades a number of new areas have been added to result in the current size of the city.

The density of population in 1901 was 5,624 km^2. In 1991, the density was recorded as 11,196 showing an overall increase of 99%. There are wide variations in the density of the population in the different areas of the city, with the city centre having very high density of population. The current density of population, 11,196 km^2, is less than that for other major cities of Indian, namely Bombay (29,894), Calcutta (23,660), Madras (21,811) and Delhi (15,480).

2.3 Population

Bangalore emerged as a million population city during the decade of 1951-61. At that time it was the seventh largest city in India. The growth of the population of Bangalore city from 1901 to 1991 is given in Table 1. Currently Bangalore is the fifth largest city in India.

Table 1

Population growth of Bangalore during 1901 to 1991.

Year	Bangalore Urban Agglomeration Population	% Growth	City (City corporation/CITB/BDA) Population	% Growth
1901	163,091	-	159,046	-
1911	189,485	16.18	189,485	19.14
1921	240,054	26.69	237,470	25.34
1931	309,785	29.05	306,470	29.04
1941	410,967	32.66	406,760	32.72
1951	786,343	91.34	778,977	91.51
1961	1,206,961	53.49	1,141,107	46.49
1971	1,664,208	37.88	1,540,741	35.02
1981	2,921,751	75.56	2,628,593	70.61
1991	4,086,548	39.86	3,264,261	24.18

The population growth of Bangalore city as well as of its urban agglomeration is uneven in different decades right from 1901 (Table 1). The growth of the city was slow up to 1941. An unprecedented growth rate of 91% was observed during the decade of 1941-51. During 1971-81, the city experienced its second loom of population growth measuring about 75% increase. The average growth rate of the city was 39% during the 1901-51 period as compared to 52% during 1951-91. The population is doubling every twenty years.

One of the major contributors to growth of population is migration. It is estimated that 110,000 of the population are life-time migrants, up to 1981 forming about 37% of the

total population. Of the total migrants 54% of the migrants came to the city during the 1971-81 period. Economic factors related to employment and/or family migration was the reason in 59%.

2.3.1 Age groups

Table 2 presents the age distribution of the population for males and females.

Table 2

Percentage distribution of population by age and sex during 1971 & 1981

Age	Males		Females		Total	
	1971	1981	1971	1981	1971	1981
<15	35.74	33.73	39.89	36.87	37.67	35.22
15-19	10.45	10.25	10.78	10.78	10.60	10.50
20-29	20.65	21.05	20.26	21.15	20.45	1.09
30-39	14.09	14.70	12.48	12.90	13.34	13.85
40-49	9.50	9.75	7.54	7.80	8.59	8.89
50-59	5.22	5.43	4.56	5.02	4.92	5.23
60+	4.35	5.05	4.49	5.48	4.43	5.26
Total	100.00	100.00	100.00	100.00	100.00	100.00

The sex ratio shows that there is a predominance of male population. In 1901, the sex ratio of Bangalore was 961 females for 1000 males and it was 909 in 1991. This ratio is Better than for many cities of India namely Bombay (819), Calcutta (827), Delhi (831), Ahmedabad (890), Lucknow (808), Varanasi (860), Chandigarh (813).

2.3.2 Marital Status

It is estimated that 60% males and 50% of females are never married. The proportion of never married females in the age group of 15-34 has shown a sharp rise in 1981 as compared to 1971 (33% vs. 20%). It is also found that the proportion of widowed/separated/divorced is as high as 50% for females in the age group of 50+ years, as compared to only 10% for males. This could be a reflection of the remarriage of men while females remain widowed.

2.3.3 Literacy

The literacy rate is 69% as per 1991 census. This was only 50% in 1961. The literacy rates of males and females are given in Table III:

Table 3

The literacy rate for Bangalore - 1961 to 1991.

Year	Males	Females	Total
1961	59.68	39.12	50.06
1971	65.68	51.27	58.95
1981	70.26	57.75	64.36
1991*	73.74	62.86	68.95

* Children in the age group 0-6 are not considered in the numerator for calculating literacy rate.

The literacy rate of Bangalore is lower than Bombay (72%), Madras (72%), Calcutta (70%) and same as Ahmedabad (69%) and better than Hyderabad (58%).

2.3.4 Religion

The religious composition of the city consists of six major religious groups - namely Hindus (78%), Muslims (14%), Christians (7%), Jains (1%), Sikhs (0.09%), and Buddhists (0.01%). The growth rates of the different religious groups is about the same as the decadal growth rate of the city population.

2.3.5 Language

The major languages spoken by the population are Kannada (34%), Tamil (23%), Teluga (16%), Urdu (14%), Malyalam (3%), Marathi (3%), and Hindi (2%).

2.3.6 Occupation

There are two definite functional characteristics. Firstly, it is a capital city. Secondly, it is an industrial city. The occupational activities are mainly secondary and tertiary activities. The proportion categorised as workers is 33%.

There is a great disparity between the males (83%) and females (18%) in the total working population (1991 data). The proportion during the last 3 decades is given in Table 4.

Table 4

Distribution of workers by sex - 1961-1991.

Year	Worker (figures in '000)		
	Males	Females	Total
1961	337.1 (86.1)	54.5 (13.9)	391.6 (100.0)
1971	435.4 (87.3)	63.2 (12.7)	498.6 (100.0)
1981	754.1 (86.7)	115.3 (13.3)	869.4 (100.0)
1991)	111.6 (82.4)	237.4 (17.6)	1349.0 (100.0)

(Figures in brackets indicate the percentage.)

There has recently been an increase in women in the working group, from 13.3% in 1981 to 17.6% in 1991. The major occupational groups are in the industries and manufacturing followed by other services and trade.

2.3.7 Population by 2001

The growth of the population in the decade 1991 - 2001 is established to be between 5.7 million and 6.2 million, depending on the base growth rate of 1981 - 91, 1951 - 91 periods.

2.4 Public Amenities

The population crisis committee, Washington (1990) report on the top 100 metropolitan cities of the world includes 9 Indian cities namely Bombay, Calcutta, Delhi, Madras, Bangalore, Hyderabad, Ahmedabad, Kanpur and Pune and rates the indicators of living standard as `poor' in all the 9 cities.

Bangalore is not located next to a major river. Till 1896, the city was supplied water without any treatment for purification. The first water supply scheme was planned at the turn of the century for a population of 0.25 million. The next major development was to bring water from River Arkavathy about 40 kms from Bangalore. The Bangalore Water Supply and Sewerage Board (BWSSB) was formed in 1964. The additional major source of water to the city is from the River Cauvery which is over 100 kms from the city. The per capita availability of water has been around 100 litres, though the goal is to have 140 litres per capita.

In the recent years there has been a perpetual shortage of power. As against a need of over 4,000 million units, the availability is 3,000 million units. This has led to periodic power cuts and limitation in supply. It is estimated that the power requirement by 2001 would be around 5,000 million units.

Roads and transport are a source of major dissatisfaction. In order to meet the transport needs of the population, the city depends totally on a road-based system. The city has inherited a narrow road system and as a result the older parts of the city have problems in easy movement of vehicles. The land used for the road network is about 17% as compared to 30 to 33% in cities of the developed countries. Another major constraint is the poor public transport system, which has led to an attendant rise in ownership of private vehicles (table 5):

Table 5

Number of registered motor vehicles per 1000 population in Bangalore city.

Year	Vehicles per 1000 population
1971	24
1981	60
1990	132

A result in the growth of the private vehicles - from 24/1,000 population in 1971, to 132/1,000 in 1990, has been the increase of two wheelers (546%), with attendant problems of road congestion. There are two major proposals to overcome the problem - namely the circular rail and overhead rail system. The city is also building its first flyovers.

2.5 Housing

The average size of the household is 5.7 and this has remained the same over the last 3 decades. The distribution of occupied residential houses and the households by number of rooms occupied is given in Tables 6 and 7:

Table 6

Distribution of Occupied Residential Houses in Bangalore.

Year	Percentage distribution of occupied residential houses		
	Pucca	Semipucca	Kutcha
1971	86.2	2.7	11.1
1981	78.8	13.8	7.4

Table 7

Distribution of households by number of rooms occupied.

Year	1 room	2 rooms	3 rooms	4 rooms	5 and above
1971	45.4	27.5	11.9	7.4	7.8
1981	45.0	27.0	12.5	15.5	-

It is notable that 45% of the households live in single rooms.

The major agencies involved in housing are Bangalore Development Authority (BDA), Karnataka Housing Board (KHB), Karnataka Slum Clearance Board, Private Housing Societies and houses constructed by individuals.

During the last decade, there has been a spurt in the multi-storeyed apartments all over the city, along with the increase in slums. There are about 400 slums in the city, accounting for 12% (over 0.5 million) of the population of the city. The number of slums was not significant in 1970 (150 slums with around 0.1 million) but currently they are straining on the amenities and act as a barrier in the planned and healthy growth of the city.

2.6 Major Activities

Bangalore city is considered ideal for setting up of industries, due to a favourable industrial climate, available economic infrastructure and the weather. Indian Telephone Industries was the first major public sector industry established in 1948. The other major industries are as follows:

Hindustan Machine tools	- 1953
Hindustan Aeronautics Limited	
Bharath Earth Movers Limited	- 1964
Bharath Electronics Limited	- 1954
Motor Industries Company Limited (MICO)	- 1951
New Government Electric Factory	- 1960

Apart from these public sector units, there are many large scale industries such as Mysore Lamp, Kirloskar Electric Company, Gust Keen Williams Limited, BPL, Escorts, L & T etc. There are about 300 medium and large scale industries in Bangalore, forming 44% of the state. The number of small scale industries increased from 1100 in 1969-70 to 20,000 during 1990-91. All these activities have important impact on the city.

3 HISTORY OF MENTAL HEALTH SERVICES

The organisation of mental health services in the city of Bangalore falls into 4 phases, during the last 150 years.

The **first phase** refers to the period of 1837 to 1937 when a small mental asylum was functioning in the city. This was in the heart of the city and small in size. Not much information is available about this phase.

The **second phase** begins with the building of the modern mental hospital in 1937 outside the city. This was built as an open hospital with a pavilion design. This centre was also a pioneer in introducing ECT and psychosurgery around the same time as the rest of the world.

The **third phase** can be traced to the period from 1954 when the All India Institute of Mental Health (AIIMH) was built as the first mental health training centre for the needs of Independent India. The AIIMH and the mental hospital worked in co-operation, with the hospital under state control and the Institute under federal support. The beginning of the training courses in psychiatry, clinical psychology and psychiatric nursing brought a lot of changes in the hospital. Some of the significant ones are the setting up of daily outpatient services, the specialised services for family therapy, children, persons with drug dependence, rehabilitation, open wards and neurological services.

In 1974, the two institutions were combined under one management to form the National Institute of Mental Health and Neuro-Sciences (NIMHANS). In the last 20-23 years, the

Institute has come to be a pioneer in a number of areas, and forms the chief mental health facility in the city.

The **fourth phase** of mental health activities are of recent origin. These are in the areas of alternative community mental health facilities (see section 3.4.), initiatives by the voluntary organisations, and both private and public general hospital units (2.3. & 2.4.).

Currently all the major general hospitals in the city have psychiatric units with outpatient departments and inpatient services. The number of private sector psychiatrists is now over 1,000 compared to a handful less than 40 years back. During the last two decades, the other mental health initiatives have been (i) school and college mental health programmes, (ii) prison services, (iii) suicide prevention, (iv) centres for de-addiction services, (v) training for staff of institutionalised children and homeless persons. All of these developments have made Bangalore the 'mental health capital' of India. The city has been the starting point for a large number of new and innovative activities, to be taken up by other centres subsequently.

4 MENTAL HEALTH SERVICES

There are a wide variety of mental health services in a variety of settings available in the city.

4.1 Facilities

4.1.1 NIMHANS

In addition to providing quality care to patients in both in-patient and out-patient settings, the department has continued its effort of offering specialised services in various areas:

i) Child and Adolescent Mental Health
The Child and Adolescent Mental Health services continue its efforts to maintain high standards of care. Its staff members continue to function as resource persons

for various governmental and non-governmental organisations. One such important activity initiated in this year was with the collaboration of a voluntary organisation, SAMVAD. It involved the designing and implementation of an interactive workshop cum survey methodology for researching childhood sexual abuse among girls. This work has subsequently been extended to focus research issues concerning disclosure and formulate strategies for interventions.

ii) Community Mental Health

The community mental health service has continued its regular services to provide service to the rural population around Sakjalawara, as well as through the neuro-psychiatric extension clinics in five Taluk headquarters. This has been consolidated and a system of recording and reviewing of the data has been developed. A major new initiative that has been made during the year in collaboration with the faculty of departments - namely clinical psychology, psychiatric social work, and nursing, is the addition of areas (other than severe mental disorders) for future development of programmes. Specifically, the focus has been on understanding and developing interventions at the level of (i) families of the mentally ill, (ii) developing a mental health programme for the child care workers, (iii) school mental health programme to cover children from primary school to the high school. In each of these areas, the efforts are towards more of prevention of mental disorders and promotion of mental health. The staff have also continued to provide support to the district mental health programmes in the state of Karnataka. Another initiative is to prepare a status report on Mental Health in India for the Independent Health Commission of India.

iii) ECT Services

The department has a highly sophisticated clinical service for ECT. This year, a brief pulse constant current ECT device was added to further augment its services. The physical structure of the ECT service is in accordance with contemporary guidelines. Specialised services are provided for medically compromised clients requiring ECT. Clients are also offered ECTs with monitoring or parameters including ECT and EEG.

iv) De-addiction Services (DAS)

After its initiation last year, the unit's service increased by two-fold this year. More than 800 patients received treatment in the past year for substance-abuse related problems. The inpatient services have been streamlined and a service audit was also undertaken to identify problems and monitor quality of care. An in-patient group therapy programme was also initiated, which is conducted thrice weekly. In addition, family groups are also held weekly. The DAS is in the process of preparing a directory of all organisations involved in the management of substance abuse problems. The extension services have been re-organised recently with a view to extend consultancy support for more Non-Governmental Organisations. The DAS also plans to continue the process of evaluation of various modalities of treatment - with a view to strengthen the management programmes.

v) HIV/Aids Services

This new activity was started in November, 1994. The HIV/AIDS Clinic runs on Saturday afternoons in the Psychiatry Outpatient Department. The patients attending the clinic are assessed for psychiatric and medical problems and appropriate interventions are offered. The activities of this facility include: a) pre- and post-test counselling, b) crisis intervention for seropositives and their families, c) medical assessment and liaison with appropriate agencies, d) networking with other governmental and non-governmental agencies for rehabilitation and long-term care, e) counselling in risk reduction for individuals engaging in high risk behaviours, and f) providing information and education to the worried well.

4.1.2 Medical Colleges

There are 5 medical colleges in the city. All of them have separate departments of psychiatry with inpatient and outpatient services.

Medical Colleges in Bangalore City:

1. Bangalore Medical College
2. St. John's Medical college
3. M.S. Ramaiah Medical College
4. Dr. Ambedkar Medical College
5. Dr. Kempegowda Medical college

A major activity of the colleges is the training of undergraduates, in addition to providing services.

4.1.3 Private Psychiatric Facilities

The institutional facility in the private sector consists of one fully specialised psychiatric hospital and a number of general hospital psychiatric units. The amount of inpatient care provided by these units are variable, as most of them use the general beds for the admission of patients.

4.1.4 De-addiction Facilities

Drug abuse and dependence in the city is almost all related to alcohol dependence. In 1997, a survey of 1680 patients admitted to 11 de-addiction facilities showed that 97% of the patients were being treated for alcohol dependent problems. Currently, a network of organisations working in this areas has been established in the city. A quarterly newsletter links the activities of the centres. The major care programme is detoxification and follow-up care. Specialised rehabilitative services are available in only 2 centres.

4.1.5 Half-Way Homes

The growth of these facilities is special to Bangalore city. Nearly ¾ of the half-way homes in the country are located in Bangalore city. This could be a reflection of the need of people coming to NIMHANS as well as the available support of NIMHANS and other mental health institutions. Except for one of the centres, all the others are of short duration (up to 9 months to one year stay) for social skills training, therapy and vocational rehabilitation.

The dates of the establishment different half way homes in the city are given in the following Table:

1. Medicopastoral Association - 1972
2. Richmond Fellowship - 1986
3. Puskara After care Home - 1987
4. Atma Shakti Vidyalaya
5. Cadabam's home for the mentally disabled - 1994
6. Family fellowship society for psychosocial rehabilitation services - 1995
7. Raju Rehabilitation Foundation - 1997
8. Kshama

4.1.6 Psychological Services

The psychological services in the city are developed to a very limited extent. They are now seen as independent professions providing services, along with psychiatrists or on their own. The common problems for which they provide services are childhood problems, marital problems, adjustment problems and stress-related disorders. They use a wide variety of interventions including behaviour therapy, psychotherapy, family therapy and group work. There is one group - ZIETWEST comprising 3 professionals who work mainly with the industrial workers. Their work involves both staff selection and human resource development. The other groups work in some of the selected schools as school counsellors. The majority of the schools and colleges do not have any psychological services. The last group work as part of the de-addiction services. Due to the paucity of personnel, there is limitation of trained professionals to work in a variety of voluntary initiatives like those with street children, women's groups, slum dwellers, etc.

4.1.7 Private Sector Psychiatrists

During the last 3 decades the private sector psychiatry has grown in a large way. The majority of psychiatrists work as individuals and use a wide variety of treatment modalities. A number of professionals working in the government hospitals also work in the evenings in the private sector. An interesting aspect is that the specialisation of the private sector psychiatrists is still very limited.

4.1.8 Emergency Services

Emergency services are available in all the major hospitals, along with ambulance services. However, there is as yet no 24 hour phone line for psychiatric patients. Emergency care is provided without involving the police in most situations. Of the centres, NIMHANS offers a continuous emergency service.

4.2 Method of Access of Services by the Population

All of the services available in the city are accessible and accessed by the general population in an 'open' manner. There is a committed system or primary, secondary and tertiary care referral pathways. Similarly, the use of private and public facilities are used interchangeably. A large factor determining the use of a service is the economic status of the patient. In addition, the reputation of a clinician or hospital also attracts specific groups of patients.

4.3 Links with Different Services

There is as yet no attempt to link the services by any system. It can be expected that there is considerable shopping around and duplication of services. The lack of linkage is a reflection of the lack of a National Health Service-like structure for the urban population.

4.4 Community Services for the Mentally Ill

At present there is no committed community level service for the mentally ill. The Bangalore city was one of the pioneers in initiating the home visiting services of nurses as early as 1978. However, this service has been only limited and not extended to cover all the ill persons. From centres like NIMHANS, and SJMC where a significant number of psychiatric social workers are on staff, they reach out to patients on a case-by-case approach. In recent times, an attempt at organising home visiting nurses is being planned by AMEND. As a result the current services are to be accessed by the ill persons and their families. This leads to variable rates of utilisation of services - more based on their perception and paying capacity, rather than the real need. The city has been home to some very innovative programmes of community services for the terminally ill, elderly persons in small pockets of the population. The need is urgent, but the infrastructure, staff, administrative support and funding is lacking.

4.5 Training Programmes

The city is host to the biggest postgraduate training centre in the country, namely NIMHANS. There are training programmes for postgraduates in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. A training programme for psychiatrists are also available at BMC, KMC, and SJMC, although the numbers are small.

In addition, a variety of training programmes for non-specialists are conducted by different institutions. These vary in duration and focus, but cover the whole range of mental health professional work. Some of the important training programs are given below:

1. Training of general practitioners
2. Training of rural medical officers
3. Training of primary care health workers
4. Training for parents of mentally retarded persons
5. Training for clinical psychologists
6. Training for social workers
7. Training for school and college teachers
8. Training for child care workers
9. Training for staff working with street children
10. Training for de-addiction services
11. Training for prison staff
12. Training for staff working with homeless persons

5 SPECIALISED FEATURES OF THE SERVICE

From the description of the population of the city and the available services, it is clear that there is a big mismatch between the needs and the services. This disparity has resulted in the development of innovative programmes in the city. The essence of these are (i) recognition of the needs of the population for mental health services; (ii) utilisation of community resources; (iii) organization of services in the non-institutional and community friendly settings; (iv) strengthening of the family support; (v) treatment in non-restrictive settings; (vi) integration of services and, (vii) encouragement to community involvement and self help in the community.

These principles have been reflected in the National Mental Health Programme (NMHP) for India, formulated in 1982. The NMHP has the following objectives :

i) To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of the population.

ii) To encourage application of mental health knowledge in general health care and in social development.

iii) To promote community participation in the mental health service development and to stimulate efforts towards self help in the community.

The approaches identified to achieve the goals are :-

i. Diffusion of mental health skills to the periphery of the health service system.

ii. Appropriate appointment of tasks in mental health care.

iii Equitable and balanced territorial distribution of resources.

v Integration of basic mental health care into general health services.

v Linkage to community development.

vi Mental health care

vii Mental health training

viii Mental retardation and drug dependence.

Of the many special features of the services in the city, the three are chosen as they reflect (i) a way of enhancing trained manpower, (ii) provide least restrictive facilities for the long-term ill persons and, (iii) illustrate how families can join to support each other as well as pressurise administrators to provide the needed services.

5.1 Integration of Mental Health with Primary Care

The basic promise for this approach is the recognition that a major part of the mental health tasks can be better done by primary care personnel. In addition, this is also the reflection of

the need to provide services in a friendly, affordable and accessible manner with the least amount of stigma. The initiatives have been modified to meet the needs of the rural and urban populations.

5.1.1 Rural Services

The rural population of the Bangalore development area has a large population spread out in small villages. On an average the size of the population of a village is less than 1000. They have limited access to easy transport and other communications. A striking feature of the needs of the mentally ill is that majority of them are living with their families and do not receive regular modern treatments. The rehabilitation is based on traditional rural agraman activities. There is high tolerance of the ill by the community and near total support by the family members.

The innovative approaches in this area of work have involved the following:

Sakalawara area: This field practice area is located about 15 kms. from the city centre. A population of 60,000 have been provided regular care through a rural mental health centre and by the organisation of weekly clinics in the villages, to provide easy access to care.

Solur Area: During the period of 1985-1996 a systematic attempt was made to study the feasibility of integrating mental health with primary health care. As part of this project all the 7 medical officers, 7 health supervisors and 35 junior health assistants were provided skills in recognition, referral, first aid, follow up and treatment (for doctors) covering a population of 96,600. The mental health care undertaken by them was systematically studied for 18 months both for the amount of care provided and the quality of care. The findings demonstrated the feasibility of mental health care by the primary health care personnel. An important outcome was the finding that for the primary health personnel to continue to provide mental health care they require at least once a month support and supervision by the mental health professionals. This study also resulted in manuals for the different categories of health personnel, training evaluation forms and health education materials. This study also formed the basis for the next phase of a large scale community mental health project for a population unit of 2 million persons.

Kanakapura Monthly Clinic: This rural clinic is a once a month activity with a non-governmental organisation (Lions Club). The mental health team of NIMHANS visits once

a month (third Saturday) and works to provide care to about 50 new patients and about 600 follow up patients. The patients are suffering from neuropsychiatric problems.

This service has been going on regularly for the last 16 years, and has been studied systematically. It is noted that more than 50% of the new patients have an illness of more than 24 months. An another finding is that, in spite of the clinic being located in a rural area, there is a drop out rate of 34% after initial evaluation and advice.

The three rural experiences highlight a number of aspects of mental health care needs of the rural population, namely - (i) there are mentally ill with continuing disability in the rural areas; (ii) they all live with the families and form part of the community, (iii) the current facilities of urban areas are not accessible to these people; (iv) it is feasible to provide essential services utilising the existing resources in the community; (v) the role of mental health professionals as leaders is crucial for innovative programmes to take roots in the community, (vi) the changes in public perception, help seeking pattern are slow to change, (vii) people reach out and accept modern methods of mental health care when provided in an accessible acceptable and affordable manner and (viii) one of the easiest step is to train the existing primary health care personnel in mental health care.

5.1.2 Urban initiatives

In the urban area, people have access not only to the big hospitals but also to the private sector general practitioners. Since in the city of Bangalore, as in other parts of the country, there is no national health service, a significant proportion utilise the services of the general practitioners in the private sector. It is estimated that about 2/3 of the care is provided by this sector.

The initiatives taken in this area have aimed to provide training in essential mental health care to the general practitioners. This training has ranged from: (i) monthly half day programmes for two years; (ii) once a week programmes for one year, (iii) once a week programmes for 16 weeks, (iv) short duration programmes of 2-3 days, (v) daily half-day programmes for 6 days, (vi) once a week programmes for 25 weeks. These different training have met the differing needs of the group of doctors.

The findings of these experiences have been (i) it has been noted that GPs are generally poor corresponders, responding poorly to postal and/or newspaper communication with a response rate of about 20%. However, they respond more positively on personal contact. This was especially effective when liaison service was available; (ii) a GP tends to jealously

protect his unique professional freedom and dreads to function as an extension or extra pair of hands of specialists; (iii) the GP expects their patients to be referred back to their care when they refer patients, (iv) a specialists plan of management are often not practicable in the primary care setting of general practice, (v) neurosis, depression, alcohol related problems, sexual problems, psychosomatic and somatopsychic problems are overwhelmingly represented in clients of general practice, and (iv) the GPs seek to acquire practical skills rather than acquire theoretical knowledge.

5.1.3. Training of personnel

A major contribution of the Bangalore city are the training packages for primary health care personnel. These have included manuals, evaluation material, comparison of different types of evaluation and preparation of audio-video materials. They have demonstrated the feasibility of training doctors in 2 weeks and health workers in one week. Uniformly the knowledge, attitude and mental health skills were low prior to the training. The training programmes resulted in significant changes in these areas.

5.1.4. Manuals

The basic manuals for training of primary care personnel have undergone a lot of changes. Current manuals reflect the needs of the PHC personnel as well as those aspects of care that can be undertaken by them.

5.1.5. Evaluation

Evaluation has been an important part of the innovative efforts. The evaluation has been at many levels, and they are as follows:

(i) Evaluation of screening instruments

(ii) Evaluation of training manuals

(iii) Evaluation of training outcome.

(iv) Comparison of different methods of evaluation

(v) Evaluation of the month-by-month mental health care provided by PHC personnel.

(vi) Evaluation of the impact of the mental health programme on the community;

(vii) Understanding of the support and supervision by the mental health professionals, for the PHC team to provide care

In conclusion, the NIMHANS efforts at integration of mental health with primary health care has firmly laid the foundation for use of this method as an important approach to meet mental health needs in a situation of limited resources.

5.2 Alternative Community-Level Mental Health Care Facilities

5.2.1 The Richmond Fellowship Society (India), Bangalore

The Richmond Fellowship Society (India) was established as a Registered Charitable organisation in the year 1986 in Bangalore, at the initiative of the Richmond Fellowship International. The registered office is located in Delhi. This was done with a view to expand the facilities of the Fellowship in other parts of the country. The objects of the Fellowship are :

i. To offer skilled help to those who are chronically mentally and emotionally disturbed and need support to be rehabilitated and re-integrated with the family and community.

ii. To create public awareness and to enhance people's understanding of themselves and the disabled.

iii. To promote mental health in the community, particularly by providing courses in personality development and humanism, and giving an opportunity to the community to interact with the disabled.

iv. To collaborate with all activities of similar organisations.

The first house of the Fellowship 'Vikas' (which means 'to blossom'), was a trial project and was set up in farm land made available by the family members of a M.M. Farms. This house was to provide residential care facilities for 10 male residents. To support this endeavour, the RF International has provided a co-ordinator, who was a professional, to run this facility. Encouraged by the success of Vikas, two years later the RF Headquarters secured financial assistance to set up a model house to accommodate 21 residents. This house was called 'ASHA' (meaning 'HOPE') and is deliberately placed in a residential area, the aim being to provide as close a proximity as possible to the larger community. The style in these two houses is basically informal, although its day-to-day life is organised by a structured programme. This reflects the ordinary pattern of an average household. However, rehabilitative activities form the core programme. Regular habits are inculcated by setting times of getting up, personal care, meals and other activities, because many residents have been incapacitated so far as normal routines are concerned. The whole morning for five days each week is geared to a work activity programme. Occupational therapy activities are set to individual needs and help residents develop a number of skills and the habit of work itself. The emphasis is on group life. Residents also have individual counselling sessions with their keyworker on the staff team. Families are involved from the very inception of placing their wards in the process, and also in the family therapy, and a 3 monthly progress review.

Referrals to these houses are made by psychiatrists. The family and the applicant are invited to stay for a trial period ranging from 3 - 7 days. This given him or her a chance to experience what the house is like and then to make a decision to live in the community. Since the establishment of the Fellowship, over 300 residents have received rehabilitation programmes, and are drawn from all over the country and from neighbouring countries.

Staff

Staffing being the crucial ingredient by which the therapeutic community stands or falls, a staff member of the therapeutic community house has to be a 'jack of all trades'. The staff member is somebody who can be therapeutic, not only in his personality and his

professional discipline, but in his daily living. Hence the RF training is formulated to train and support the staff to stay on this job.

Each house has a staff team of one staff member for at least 3-4 residents. Their role is to encourage positive interaction between community members, to give support to individual residents and to carry the final responsibility in the welfare of the whole household. They keep in touch with the residents, family, and the psychiatrist, as and when necessary. The staff is also responsible for the day-to-day administration of the home. The staff come with the background qualification of clinical psychology, or of medical psychiatric social work, and also receive training under the training programme of the Fellowship. They are also supported by volunteers coming from the local area and volunteers are a link with the local community.

Training Programme

There is no other training centre in India with the emphasis on the therapeutic community approach. The Richmond Fellowship International placed a training office for a period of 2 years to start a training programme at Bangalore. In 1989 an in-service training programme was organised by the RFS with its staff who are already working in the 2 houses. This was a 10 months course with 2 hour sessions twice a week. Based on this experience, the RFS (India) modified the duration of the course of the in-service programme from 10 months to 4 months duration. The Fellowship organised a national workshop in the year 1992 on Rehabilitation of the Chronically Mentally Ill - Training and research needs. The Fellowship received support from the European Commission for this purpose and also from the Department of Science and Technology, and Indian Council of Medical Research, bodies of Government of India. Based on the recommendations arrived at at this workshop, the duration of the training programme is now held once in a year of 6 months duration. From 1989 to 1995 the Fellowship has trained 39 para-professionals. The trainees have come from different parts of India. The Fellowship has also made a video on the work of Asha and the Richmond Fellowship approach to the therapeutic community with suitable modifications to meet the Indian life-style and social and cultural milieu.

As part of the training and manpower development programme in the year 1992, and also to explore the possibilities of setting up facilities in different parts of India, the Fellowship organised an outreach programme in collaboration with University Departments and Voluntary Agencies in 7 other centres.

Future Developments

The Fellowship has plans to extend the facilities to other areas as well. These include :

i) Setting up of **half-way homes** in other parts of the country in association with voluntary organizations, the guidelines for which have been laid down by the Governing Council of the Fellowship.

ii) **Group Home:** From 2nd October 1995, the Fellowship started a Group Home facility (long stay home) 'Jyothi' ('Light') at the request of several families. The guidelines provided by the professionals discussed at the Symposium on 'Long Term Care for Chronic Schizophrenic Patients' held in May 1994. This facility is established very close to Asha and can accommodate 12 residents.

iii) **Day Care Centre** with Vocational Training Facility. The Fellowship has received nearly 1,900 sq. mtrs. of land on a 99 year lease basis from a philanthropist. The Government of Karnataka has permitted to set up the Centre on this land. The plans for the building have been approved and the work is about to begin. This centre will also house a training college and library and it is proposed to set up one more half-way home in the land available there. The total estimated cost of this project is about Rs.62 lakhs for the building alone.

iv) **A Half-Way Home** for the rehabilitation of alcoholics and drug addicts at Tumkur, Karnataka, in association with RF Aradhya Charitable Trust; for this purpose a separate trust call the Richmond Fellowship Aradhya Charitable Trust has been set up. The Ministry of Finance, Government of India, has extended 100% tax exemption on donations made to this project.

v) A low cost rural project for **rehabilitation** of the mentally ill, 60 kms from Bangalore is being processed. The emphasis will be on rural based technology of sericulture, horticulture, floriculture, including utilising the facilities at the Industrial Training Institute. It is also proposed to enlist the support of the families of this village for providing expenses for this half-way home on a sharing basis - i.e. one day expenses by each family.

5.2.2 Medical Pastoral Association (MPA)

The Medical Pastoral Association (MPA) in Bangalore was founded in 1964 by a small group of dedicated men and women, members of St Mark's Cathedral, pastors, doctors and other caring professionals and lay persons. MPA was one of the first voluntary organisations in the country concerned about the physical, mental and spiritual dimensions of health of individuals, their families and the whole community. MPA, an autonomous non-profit secular body, was registered in 1972 under the Mysore Societies Registration Act of 1960.

The initial work of MPA was with alcoholics and with people who had attempted suicide. MPA has trained several batches of concerned people in suicide awareness and how to help depressed people. The Managing Committee of MPA strongly felt the need to help in the rehabilitation of partially recovered mentally ill persons, as no such facility existed at that time. After much searching, a site of about an acre was procured on a 30 year lease from the City Corporation of Bangalore. In 1976 four persons were initially admitted as residents and housed in a room of the administrative block which was ready at the time. In 1978, the Half-Way Home for recovering mentally persons was opened - the first in India, placed in the general community.

The Half-Way Home

The Half-Way Home, a big cottage - six rooms with three beds in each, another room for the lady staff to reside, and one of the house parents' office, three halls - for occupational therapy, recreation and dining, a kitchen and a store. The Navjeevan Hostel, a two-storeyed building with eight rooms with three beds each was added later. The Administrative Block is double-storeyed and includes the Bangalore Mental Health Information Centre.

Clientele

The Half-Way Home (HWH) as the name implies is a transitional home and not a psychiatric treatment facility. It has the atmosphere of a big home with house-parents, staff and fellow residents who mingle easily and know each other well. Patients who have been

treated in psychiatric hospitals or by psychiatrists are carefully screened by MPA's consulting psychiatrists at NIMHANS and then interviewed by the Admissions Committee consisting of Secretary, Administrator, House-parents, and Senior Counsellor. They are admitted provided that their medication is stabilised, and they are ready for the HWH programmes. To assess this, a trial period of a few weeks is necessary. A patient who is not ready tends to affect the morale of other residents who are learning daily living skills and can also be a real demand on the staff, by requiring constant attention. The duration of stay is 9 to 12 months.

Staffing

An Administrator is in charge of administrative aspects including the routine office work, with the help of an accountant, typist and an attender. A mature and experienced couple are employed by MPA to be the house-parents to see to the day-to-day running of the MPA, and are in charge of the helping staff - cooks, gardener, etc. The counselling staff are recruited from MA Degree holders in Clinical Psychology or Social Work. They are employed by MPA, generally full-time, and occasionally part-time. There are usually about four counsellors for about twenty residents. Some of the counsellors reside on the campus and take turns to do the duties of the house-parents on their day off. A warden is appointed to look after the hostel.

Staff members get regular in-service training, attend conferences and share experience with others in the field. There are also special team building sessions to help avoid burn-out.

Community Support

There is a remarkable contribution from the community in Bangalore who participate in the organisational activities. At the Annual General Body Meeting of MPA, the members of the Management Committee are elected - dedicated volunteers from all walks of life. In addition to helping office bearers in making major decisions, most members are chairpersons of standing committees and participate in programmes.

There is strong support from doctors of NIMHANS, who make both organisational and individual personal contributions in running the HWH and helping to organise public

programmes. Other mental health professionals from India and abroad willingly share their expertise.

Methodology

MPA follows an eclectic approach to rehabilitation. Activities at the HWH are designed to improve specific deficit areas of the residents. A very structured time-table is drawn up and residents are required to follow it and attend all programmes. Common problems seen in most residents when they are first admitted is a lack of volition, inability to get up in the morning, little or no personal hygiene, no interest in activities, reluctance to take medication. They are generally slow and lethargic. Problems of irritability and aggressiveness may erupt unexpectedly and staff members have to learn to deal with each crisis using their own expertise. Self pity, depression, suspiciousness, boredom, inability to make confident decisions are also problems to be tackled. This is done in a loving, caring, yet disciplined manner by the entire HWH community and through a systematic range of therapies - occupational, art, play, music, group therapies, and individual counselling. Independent living skills and social skills have to be learned. Programmes at HWH for mental stimulation include Quiz and Current Affairs - reading of newspapers is encouraged so that they are aware of the outside world. Classes in English and value education are conducted. For physical stimulation, aerobics, games, gardening and walking are encouraged. Yoga helps to calm their inner agitation. Art in various forms and using clay in pottery is found to have healing properties. Cooking is also a rewarding programme.

Besides this, regular outings are organised for the residents - movies, restaurants, exhibitions, to teach them responsibility, handling money and mixing in the community. The residents are expected to be rehabilitated sufficiently within one year to return to their families or to take up jobs to support themselves and live independently. The current occupancy of the HWH is 25 residents. MPA also provides a Day Care facility where a person can attend all the programmes and return home each evening.

The Hostel

Arising out of a need recognised from the running of the HWH, MPA's second project, the Navajeevan Hostel, was opened in 1988 on the same campus as the HWH. This Hostel is

for residents who, after completing their rehabilitation programme of about one year at HWH, are functional enough to hold a job - full-time or part-time, or are undergoing vocational training in an external location. After a stressful day at work, returning to a safe and caring environment where counsellors are available by appointment, instils a sense of security and independence in the hostel-dwellers. As there were practical problems in working women residents staying in the same hostel, especially as supervision is minimal. The self-help initiative promotes a friendly and familiar environment for the suffering families to gain from the experience of others.

5.3 Self-help Group for Families of Mentally Ill Individuals

5.3.1 AMEND

It was a sheer desperation and loneliness that made a schizophrenic conceive AMEND as a self-help group for patients and families. The suffering parents took it up and others like them gave shape. This is how the initiative started, at a borrowed premises with borrowed furniture.

Since 1992, the member has been growing slowly but steadily. Today, it has a strength of around 40 families. 'When we met for the first meeting, even though we had not met each other, we felt we knew each other'. Our experiences were sufficient to lay the foundations. The emotional bonding is our first and foremost commitment. In fact, some families are not able to appreciate because they are in the trap of misconceptions and myths about schizophrenia. For these families, emotional support or sharing and learning comes last in the agenda. The day-to-day agony of going through with patient drives them unwillingly to look for long-term institutionalisations.

The families of the mentally ill need help. Some of the storms that can sweep over the families when schizophrenia strikes are: sorrow, fear, disruption of family relationships, disruption of family health, despair, anxiety, guilt, difficulty in accepting the illness, a feeling of isolation, exhaustion of spirit and resources, and apprehension about he future. There are hundreds of families who need help. Someone they love is suffering from

schizophrenia. But these families are isolated. They need to meet and find emotional companionship. New demands were made on the members to guide each other and share each other's experiences with a view to learn about various aspects of coping with the stress - a problem about which they know almost nothing. Mental health educational programmes are aimed at normal people coping with normal stress problems. The affected families become aware of the facts the hard way after living with the ill person for a number of years. The self-help initiatives promote a friendly and familiar environment for the suffering families to gain from the experience of others.

From one stage to another, AMEND gained small strengths. Emotional support, shared learning led to feeling for each other. The AMEND family is always there to help in a crisis and became a way of hope to all of us. In almost all the meetings, the repeated emphasis is on what can we do to promote wellness of the patient and prevent crisis and further deterioration. Many families have had exposure from those who have benefited from family therapy services. It was also found that the attendance of the meetings varied with the agenda. Lectures from leading psychiatrists attracted the maximum crowd; similarly any input on long term care and rehabilitation was also well attended. The crux of this successful transaction between families lay in the fact that they all shared the same agony which the professionals can only talk about.

AMEND Data Bank built with the kind co-operation of the World Schizophrenia Fellowship and other institutions like NIMHANS was an added help to the affected families in understanding the ailment, and handling crises before one could reach professional help.

Besides self-support, information dissemination was the next major landmark in AMEND's modest achievements. With the immense support given by professional psychiatrists, psychiatric social workers and other NGOs, we have reached a stage where our focus has shifted from ailment per se, to its management. Our new members who come with the hope of finding instant solutions, are encouraged to look into the benefits of multi-therapy treatment models and not get bogged down with the conventional syndrome of chronicity of schizophrenia. Knowledge of the new drugs, like Clozapine, etc., have raised our hopes, pushing our agenda into action plans.

Very soon AMEND will be appealing to the Drug Controller of India for making recent drugs like Clozapine available in India. Similarly, we are also trying to get the term 'Disability' redefined so as to make the benefits of the disabled available to the mentally ill as well as under the Disability Act of India.

Self-help groups can go a long way in educating the public, raise funds for research, and fight for better legislation. They can lend emotional support to families. Families no longer need feel isolated. Talking to others helps. Relatives see their secrecy and come forward to admit they have a problem. Many times a mentally ill person creates havoc in family relationships. Compassionate counselling by trained therapists arranged by self-help groups can lead to meaningful relationships again. Friction between husband and wife as to how to handle a crisis is turned into a supportive effort by the parents to deal with the matter in an emotionally restrained way.

Self-Help Initiatives

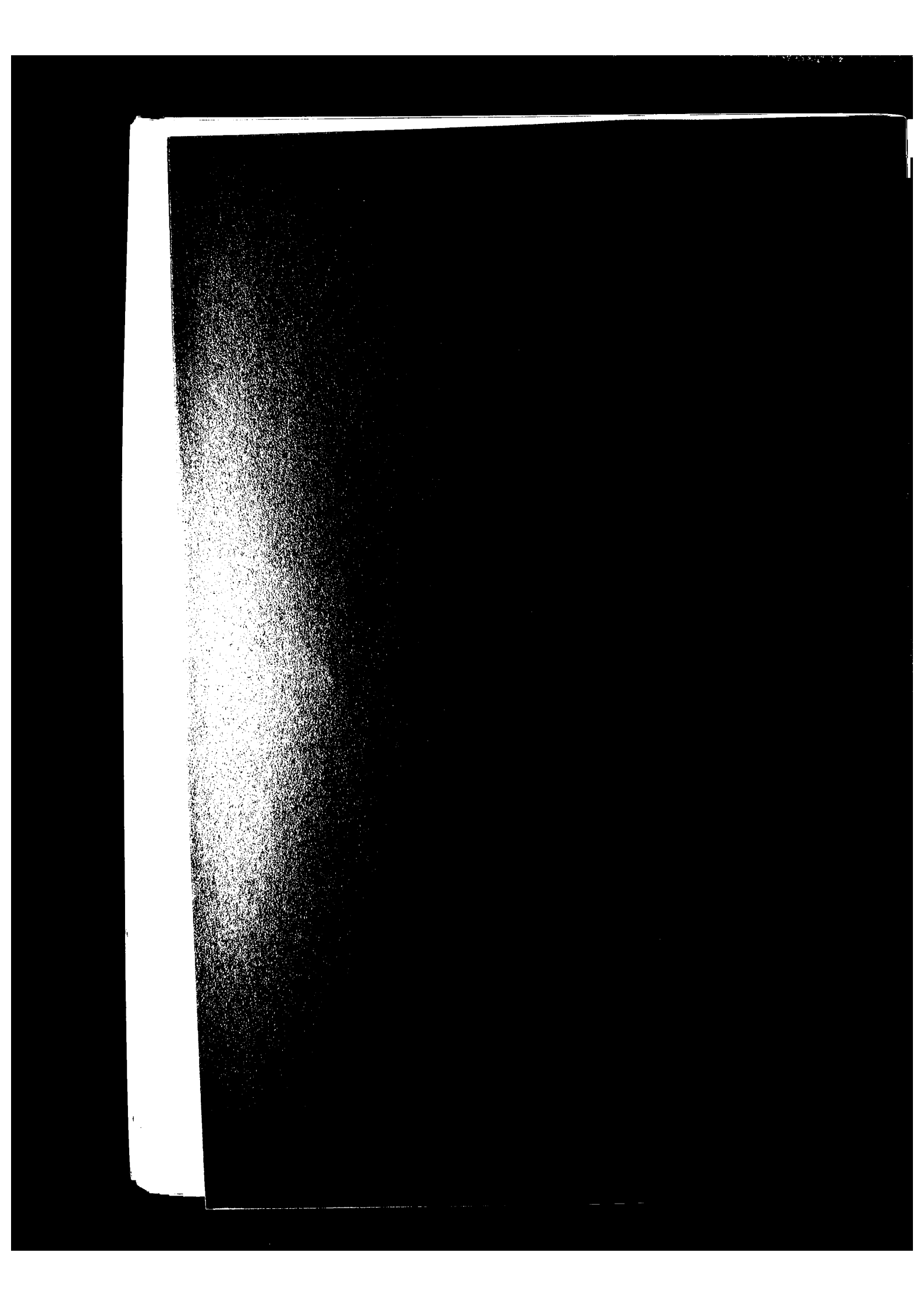
Some of the self-help initiatives taken by AMEND are :

- Lectures by well know psychiatrists and social workers.
- Establishment of a data bank of latest information on schizophrenia, misconceptions and myths about schizophrenia. The circulation of appropriate information has helped many families.
- Crisis management through networking with other AMEND members. A few nursing homes have come forward to help in emergencies so that calling the police is made the last choice.
- Steps to make available the latest medicine in the field.
- To educated the families about their right to information on their wards / children, how to communicate with the consultants is a big issue for some of our members.

Additional measures on which work is yet to be started are :

- Decent housing for patients
- Recreational facilities
- Income support - pension
- Rehabilitation
- Mental Health education - advocacy issues.

Timely intervention and care is the need of the day. It is time for the families to meet each other and for the world to meet them, and there is strength in unity. From a position of dependence we are striving towards interdependence with all those fighting the battle against mental illness. Family support to the patient is a major resource, and we in AMEND cherish it.



CHAPTER 4

MENTAL HEALTH IN THE CITY OF COPENHAGEN, DENMARK

Marianne C. Kastrup

Department of Psychiatry
Copenhagen University Hospital, Hvidovre
2650 Hvidovre
Denmark

CONTENTS

1. THE CITY OF COPENHAGEN

1.1 General Characteristics

Copenhagen is the capital of Denmark. Within the boundaries of the municipality of Copenhagen an independent municipality, Frederiksberg, is located with approximately 90,000 inhabitants.

1.2 Social characteristics

The city has a number of industries such as breweries, electronic and pharmaceutical industries. The city houses the largest university in Denmark, the University of Copenhagen, which is a State University. Moreover, the city houses a number of other educational institutions such as: The Royal Veterinarian and Agricultural University, The Technical University, The Music Academy, The Academy of Fine Arts, and The School of Economics and Business Administration. The city has a seaport and an airport. The airport is the main airport for all the Scandinavian countries, and both ports are related to the fact that Copenhagen has a rather large tourist industry.

Social Problems: The city of Copenhagen is faced with a range of social problems. The population is skewed with an overrepresentation of elderly and single persons. In the inner city there is a small population of homeless people some of whom live as "bag ladies", others live in various types of hostels. A large proportion of this population suffers from mental disorders. The city has a concentration of persons exhibiting problems of alcohol as well as other substance abuses.

Copenhagen also comprises a large immigrant population concentrated in certain areas of the city. This concentration has consequences both for the school populations - resulting in high proportions of immigrant/non-Danish speaking children - and for gang crimes.

1.3 Population Statistics

Copenhagen had its peak population of 668,105 inhabitants in 1950, but subsequently the population has slowly decreased to the present population of 471,300. The average **expected lifetime**, in the region of Copenhagen, in the period 1988-89 amounted to 68.2 years in men and 75.6 years in women. The average life expectancy is lower in Copenhagen than in the counties surrounding the city.

The total **alien population** in the city amounted in 1995 to 44,661; of which the largest group, namely 15,550, originated from Africa and Asia, 12,130 had origin in Europe outside the E.C. and Scandinavia, 7,911 originated from E.C. countries, and 5,169 originated from other Scandinavian countries. The remaining originated from other areas of the world.

The **unemployment** rate for the population with residence in the municipality of Copenhagen is 14.2% of the registered labor force, compared to an unemployment rate of 10% of the entire Copenhagen region including neighbouring counties. A total of 18.7% of the male population in the municipality has experienced unemployment, compared to an average of 12.1% in the Copenhagen area. In women the corresponding figures amounted to 15.1% in the municipality of Copenhagen and 11.9% in the Copenhagen region.

The enrollment capacity of **institutions for children** and young people showed in the municipality of Copenhagen that 48.7 per 100 inhabitants were enrolled, compared to 40.4 in the Copenhagen region as a whole. The city had a lower proportion of children in municipal preschool classes with 73% of 6-year olds in Copenhagen compared to 85% in the Copenhagen region as a whole.

The population of the municipality of Copenhagen showed relatively less affinity with the **state church** than the Copenhagen region as a whole. Among children born in 1992 51.7% were baptised compared to 67.5% in the entire region. Of those that married 47.3% in the municipality of Copenhagen were married in a church compared to 51.4% in the whole

region. The proportion of the population that paid church tax amounted to 77.6% in comparison with 82.5% in the whole region.

Copenhagen is a **relatively deprived area** measured by the average income and allowance. Thus the average income and allowance for taxable persons were calculated to 119,500 D.Kr., compared to 139,600 D.kr.in the region as a whole. Considering the relative distribution of taxable persons, the same tendency appeared as Copenhagen had a relatively larger proportion showing a low income and a relatively small proportion of persons with a high income compared to the region as a whole.

Furthermore, the citizens in the municipality showed relatively less use of their **democratic rights** in the local-/regional elections as the percentage voting in Copenhagen was relatively small when compared to the neighbouring municipalities. The same was the case for the election to the Danish Parliament, where only 80.1% of the Copenhagen citizens, compared to 84.2% of the region as a whole, voted at the last election (Statistical Yearbook, 1995).

1.4. Social Services

Denmark has an elaborate social system providing social benefits for citizens in need. The *"Bistandslov"* (Social Help Act) from 1976 is the legislative body regulating the provision of social services that are administered by and under the responsibility of the local municipality.

Copenhagen is divided into 14 boroughs, or social districts, each with its own social district centre, but all under the responsibility of the social magistrate of the municipality. In order to rank the districts according to **severity of social problems** the following indicators have been used:

- The number of unemployed age 16 - 66
- The proportion of inhabitants receiving social benefits age 18 - 44

- The proportion of early receivers of pension i.e. prior to the age of 67.
- The proportion of inhabitants with a total income below 100.000 D.kr. 1990.

Similarly, the boroughs have been ranked according to their use of psychiatric in-patient care. A comparison of the two rankings showed that the five boroughs ranked as having the greatest social problems were identical with those with the relatively highest use of psychiatric hospital care (Sundhedsdirektoratet, 1993). Each social district centre is responsible for a variety of services, including home help, meals-on-wheels, and district nurses.

To assess health issues in cases presented to the social district centre, each social district receives consultation services from a G.P. and a specialist in psychiatry.

2 GENERAL HEALTH SERVICES

2.1 Primary Health Care

In Denmark, the general practitioner (GP) plays a key role in the co-ordination of the various medical interventions with contact between the patient, relatives, the local network, and other health and social services. All citizens are entitled to a GP and usually they enroll on the list of a GP close to their residence.

The GP also plays a central role in the diagnosis, treatment, and follow-up of psychiatric illness, as a substantial proportion of all contacts having a psychological aspect will not be referred any further, but will be treated in primary care. In relation to hospital care, the general practitioner will in particular be involved when a patient is discharged, as the responsible co-ordinator of the various therapeutic activities. The GP also refers the patient to secondary institutional care or to private specialists.

The City of Copenhagen has appointed a number of GPs as liaison officers, with the aim of facilitating collaboration between primary and secondary health services, each of whom has responsibility to promote the interaction between a specific department and the GPs in its catchment area.

2.2 Other possibilities for help in the community

The social services have various institutions that provide services for the mentally ill, such as special housing for mentally ill, welfare institutions for socially deprived persons, for homeless persons, and a variety of day centres for the mentally ill. In the city there is ample opportunity to receive **psychological help**. The limitation is, however, the fact that such consultations usually have to be paid by the patient without possibility for reimbursement. Partial support from the National Health Service for psychological help related to various forms of crisis intervention was established in 1992 on a project basis.

2.3 Specialists in psychiatry

A number of specialists in psychiatry provide services independently of psychiatric institutions. These specialists usually work in their own clinic and receive patients referred from GPs. The service provided will typically be free of charge, covered by the National Health Service, but with a limit on the annual number of consultations thus provided. Psychiatrists in private practice in Copenhagen in 1993 numbered 30, of whom 13 were full-time.

2.4 Institutional psychiatric care

According to Danish legislation, health services - as opposed to social services - are the responsibility of the regional authorities (counties); with the exception of Copenhagen, which has status as both municipal and regional authority. The municipality of Copenhagen is responsible for the overall health services, and the local politicians have the political and

economic responsibility for the quality and level of services. All medical services are free of charge and financed by the taxation system.

3 DEVELOPMENT OF PSYCHIATRIC SERVICES IN DENMARK

The first hospital for psychiatric patients was established in 1816 in the Sankt Hans Hospital, located approximately 30 km from the city. At that time the provision of a ward for the mentally ill was considered a task for the local municipality, but no municipality apart from Copenhagen had the funds to carry out this task.

In the light of this, the Danish state took the initiative to establish the necessary institutions for the mentally ill, and at the turn of the century the state took the total responsibility for the psychiatric hospitals and gave the municipality of Copenhagen compensation for running its own mental health service system. Apart from the psychiatric hospital, the city of Copenhagen established psychiatric departments at some of its general hospitals to provide acute and short-term treatment. Patients requiring longer admissions were transferred to the psychiatric hosptial.

3.1 The Development of Community Mental Health Services

In 1976, the responsibility for psychiatric services was transferred from the state to the regional authorities (counties). The principle of a sectorized psychiatry emerged concomitantly with the change from state to regional responsibility, and has remained almost unchanged as a main organizational principle.

Over the last decade Denmark has further experienced the development of a variety of community psychiatric services. Several different models have been developed, but each sharing some of the same principles: that community care should focus on multidisciplinary teams with easy accessibility and continuity of care and with a low threshold for referral;

that extramural activites, including that establishment of social networks, have a high priority; and that evaluative and preventive aspects should play a central role.

Copenhagen offers extensive community psychiatric care.

Radical changes have thus taken place over the last decade, with an extensive increase in the extramural care, out-patient care as well as community psychiatric care, and with a drastic decrease in the number of psychiatric beds provided.

3.2 Mental Health Services in Copenhagen

Three major plans for the mental health services in the municipality of Copenhagen have been developed in the last decade. The plans from 1987 (Direktoratet, 1987) and 1993 (Sundhedsdirektoratet, 1993) concentrate on the services offered by the municipality of Copenhagen, whereas the last plan from 1996 (Sygehusplan H:S 2000, 1996) was based on the development in 1995 of a new concept, the Copenhagen Hospital Corporation, comprising the services offered by the municipalities of Copenhagen and Frederiksberg.

3.3 The Psychiatric Plan of 1987

In 1987, the city published its psychiatric plan (Direktoratet, 1987) for the years 1988-2000. The city had at that time three psychiatric departments located at three general hospitals:

Kommunehospitalet	32 beds
Bispebjerg Hospital	101 beds
Rigshospitalet	55-60 beds

Further, the mental hospital, Sct. Hans Hospital, had 923 beds used for long term treatment. The overall objectives of the Psychiatric Plan for the city were as follows:

1. To reorganize the psychiatric mental health care in order to **provide more effective support at an earlier point** to patients with mental disorders in their

own surroundings. It is to be expected that a number of psychiatric disorders may thereby be minimized, if not prevented, and patients enabled to function as far as possible on their own.

2. To organize psychiatry in such a way that **treatment will be the least invasive** possible for the patients concerned.

3. To promote **collaboration between general practitioners and hospital services** in order to support the work of the general practitioners in the area of psychiatry and to collaborate with the private practising psychiatrists in the organization of community psychiatry.

4. To extend the existing **collaboration** between the psychiatric health services and the activities that take place in **private or semi-public regimen** aiming to support persons with psychiatric problems, e.g. by strengthening their own social networks.

5. To provide more suitable **frames for collaboration** regarding the individual patients between the health and social services.

6. To expand the **liaison psychiatric services** related to general hospitals, thereby improving and facilitating collaboration between psychiatric and general health care.

7. To establish **specialized treatment** of certain patient categories.

8. To work for the **deinstitutionalization** of psychiatry by the transferral of treatment capacity from the psychiatric hospital to smaller units in the city of Copenhagen and by extending extramural care.

9. To improve the **physical conditions** of the psychiatric services.

10. To strengthen **research** and **developmental activities** in the field of psychiatry.

11. To strengthen recruitment and **general staff policy** within the field of psychiatry, thereby creating better working conditions for health personnel.

12. To establish and improve available offers for **further education** of psychiatric staff.

Main Proposals of the Psychiatric Plan:

In order to reach the above-mentioned goals the Psychiatry Plan for the city of Copenhagen includes a number of proposals (Direktoratet, 1987) among which the following deserve

mention:

1. The present **allocation of resources to psychiatry** should be maintained in the years to come. Psychiatry should be exempt from any reductions in the health budget that may be brought forward.

2. The psychiatric services should be organized in such a way that **acute and general psychiatry** should be taken care of by the psychiatric departments placed at general hospitals.

3. The aim should be that at a given general hospital the psychiatric department has the same catchment area as the other hospital departments.

4. The psychiatric departments at the general hospitals should be reorganized in such a way that each unit should serve the same **catchment area** as a specific community mental health centre, with which the unit should establish close collaboration.

5. Establish **community psychiatric centres** in the entire municipality of Copenhagen each with a catchment area between 25,000-55,000 inhabitants. Based upon the evaluation of the first two pilot centres the remaining community psychiatric centres will be organized.

6. The number of **beds at the psychiatric hospital should be reduced** and the hospital should gradually be reorganized in order to provide care for clearly defined patient categories.

7. Special attention should be given to the future **integration of child psychiatry adolescent psychiatry respectively,** with a focus on the co-ordination between hospital, social and school authorities.

8. The program for establishing **better physical conditions** at the psychiatric departments for psychiatric patients should be carried out.

9. As one of the University Hospitals in the city of Copenhagen in 1987 did not have a psychiatric department, such a department should be established.

10. A steering committee should be established in order to provide a fast expansion in the number of collectives and other **housing establishments** for psychiatric patients.

11. **Special courses** should be provided for all staff seeking employment at a psychiatric department in order to prepare them for their tasks. Furthermore, post-graduate training of staff working in psychiatry should be continuously provided.

12. A specific **post-graduate training** for nurses in mental health should be established.

Assumptions for The Psychiatry Plan:

In the Psychiatry Plan an overall objective was to enlarge treatment capacity through a reorganization of psychiatric care from in-patient to out-patient care. Consequently, a reduction in the total number of beds does not necessarily reflect a reduction in the treatment capacity within mental health care.

Gerontopsychiatry:

The demographic development in the municipality of Copenhagen shows, as mentioned above, a general reduction in the population, with a continuous reduction in the number of elderly people with psychiatric disorders. Furthermore, it is anticipated that elderly patients with light or moderate psychiatric disorders will be increasingly integrated into the normal nursing homes, and not specific psychiatric nursing institutions. The combination of increased out-patient and day hospital care, together with an expansion of community help and nursing, will result in an increasing proportion of elderly people with minor psychiatric disorders remaining in their own homes, instead of being admitted.

3.4 Community Psychiatry in Copenhagen

A main element in the Psychiatry Plan (Direktoratet, 1987) was the proposal to introduce community psychiatry in the entire municipality of Copenhagen. As early as 1981 it was suggested to introduce community psychiatry, and the proposal to establish two pilot community mental health centres as a first step towards introduction of community psychiatry was discussed in the City Council in 1987.

A main objective in establishing community psychiatry was a wish to allow the patient to remain as much as possible in known surroundings, and to support and treat the patient in the local setting. The idea is also to keep patients out of institutions, to treat them in the vicinity of their home, to help strengthen the local social support systems, and to facilitate the collaboration between the community mental health team, the local social centre and the

primary health care system. Ultimately, the hope was to help prevent the emergence or exacerbation of psychiatric problems.

Prior to the introduction of community mental health care it was decided that the community centres should primarily concentrate their work on adult psychiatric patients, and that admissions should not take place in the centres, which would be open in normal working hours. Furthermore, the centres were meant primarily to deal with the more chronic psychiatric population, offering:

- Assessment of referred patients
- Out-patient treatment including psychopharmacological treatment, various psychotherapeutic approaches, supporting and strengthening social networks
- Day-centre activity including access to various workshops in order to stimulate patient activities.

The idea was that the staff working at the centres would be multi-disciplinary, with each group utilizing their specific abilities. The number of community mental health care centres in the city should, when fully established, equal the number of local social districts and each should have a catchment population around 25,000-55,000.

3.5 Evaluation of Community Mental Health Centres

The services of the first two Community Mental Health Centres have been thoroughly evaluated by a group of researchers attached to the University of Copenhagen (Knudsen et al., 1992). The evaluation took place 2 years after the establishment of the centres. Among the main findings are the following:

1. Establishment of Community Mental Health has only to a **very limited degree replaced in-patient treatment**.
2. The **core group** for the Community Mental Health Centres have been adults with **psychotic disorders, in particular of a chronic nature**, and the centres have been able to reach a group of persons with psychotic disorders who have not

previously received any treatment.

3. A group of patients with long term contact with psychiatric services, and who previously were admitted for long periods of time, have been able to manage without admissions thanks to the Community Mental Health Centres. The **quality of life** and satisfaction of this particular group also seem to have improved.

4. As regards the number of staff and the type of staff, services in community psychiatry should be organized in order to utilize available resources at an optimum, and it should be recommended to **recruit staff**, that have been **working at the hospital department related to a given centre**.

5. The evaluation showed that **within the city** of Copenhagen there are **differences** with regard to demographic distribution, level of **psychiatric morbidity**, and that the establishment of Community Mental Health Centres should take such differences into consideration.

6. Close **collaboration** between **community mental health** and **general practice** and **social services** should be given high priority.

As regards the balance between community mental health and in-patient care, the introduction of such centres did not automatically lead to a reduction in the need for in-patient care and there seemed no sign of a reduced need of this type of care. Such facts need to be taken into consideration when developing further the psychiatric services, and it is emphasized that a further allocation of resources from in-patient to extramural care may lead to difficulties.

4 THE PSYCHIATRIC PLAN OF 1993

The City Council of Copenhagen revised the psychiatry plan of 1987 emphasizing 2 main points (Sundhedsdirektoratet, 1993):

1. Strengthening the collaboration between the health services and the social services by providing maximal social support as early as possible.

2. Re-evaluating the balance between community mental health and stationary psychiatric care.

The overall aim of the revised plan was to provide living conditions for citizens with mental disorders which approached as far as possible those of the normal population. Particular emphasis should be given to patients with various kind of abuse. During the last years, a number of initiatives focusing on the social aspects have materialized, including special housing, temporary and permanent, for citizens with mental problems, day centres, various types of cafés and activity centres. Furthermore, leisure and culture activities have been established.

A new concept in the social services was introduced, namely that of a **"support & contact person"**. This person's primary task was to support persons with severe mental disorders in managing their daily life. Such help could include acting as a liaison between the patient and various authorities, landlords, neighbours, general practitioners, etc. Ideally, this person would make contact with the patient during admission, and plan for the social rehabilitation following discharge. This intensified interaction between health and social services (which also occurs on a more concrete routine level with the aid of a treatment plan) should support patients who have a great need for both social rehabilitation and for the structuring of daily living.

Another new initiative was the development of social **"acting plans"** for this vulnerable group of patients, with the aim that close collaboration between health and social services should ensure that the psychiatric treatment plan and the social acting plan are compatible. Based upon the evaluation of the Community Mental Health Centres (Knudsen et al, 1992), the Psychiatry Plan of 1993 also stated that in future Community Mental Health Centres should recommend the core group to be persons with severe mental disorders (in particular psychoses of a chronic nature) who are in need of long term care. Patients with other kinds of mental disorders could be treated only to the extent that the centre has extra capacity,. The plan further suggests the establishment of a psychiatric ambulance service, at least on a project basis.

4.1 Organization of Psychiatric Care

The overall organization of the mental health services in Copenhagen did not change with the revision of the plan. Thus the hospital based psychiatric services include:

1. Emergency psychiatric clinic open 24 hours.
2. In-patient facilities for shorter or longer periods.
3. Day Hospital services related to psychiatric departments.
4. Out-patient treatment related to the psychiatric departments.
5. Community mental health clinics providing out-patient and day-patient service.

Capacity of the Psychiatric Departments: in 1993 the municipality of Copenhagen had (Sundhedsdirektoratet, 1993) the following psychiatric departments:

Hvidovre Hospital (established in 1989)	120 beds
Bispebjerg Hospital	99 -
Kommune Hospitalet	72 -
Rigshospitalet	52 -
Psychiatric Hospital (Skt.Hans)	525 -

The psychiatric hospital comprised departments for forensic patients, for patients with problems of abuse, for younger psychotics, for long-term care and for general psychiatry. Over the years, the role of this particular hospital has been thoroughly discussed, with the issue of having general psychiatric beds at the psychiatric hospital being particularly debated. It is generally agreed that a specialization of care, such as forensic psychiatric services or services for patients with abuse, could benefit from special departments at the psychiatric hospital; but on the other hand it may be less evident why the hospital should continue to have departments with general psychiatric care in the light of the fact that the general psychiatric departments cover the entire city.

4.2 Treatment Plans for Individual Patients

As part of the **Mental Health Act from 1989** the Danish National Board of Health has laid down guide-lines regarding treatment plans for patients admitted to psychiatric departments. Within one week of admission a treatment plan should be available, comprising a description of the present symptomatology, the need for further investigations and therapeutic interventions. The treatment plan should comprise information about medical as well as social interventions, together with both short and long term treatment goals, the approval by the patient and the date for renewal of the treatment plan. For patients with an extended need for various kinds of social interventions, the Psychiatry Plan of 1993 suggests (Sundhedsdirektoratet, 1993) that the collaboration between health and social services with respect to the social aspect of the treatment plan should be intensified. The idea is to out-line this plan during the admission in close collaboration with the user of psychiatric care, the case manager in the department, and a representative from the social services.

The **social part** of the treatment plan may comprise a description of the various social interventions that need to be carried out, such as problems concerning housing, financial support, educational activities, work, and so on.

4.4 Comments on the Psychiatry Plan

The municipality of Copenhagen has a Medical Advisory Group that commented on the Psychiatry Plan (Københavns kommunes lægeråd, 1993), and concluded that the total number of beds in Copenhagen is too small, and should be increased by about 50. Furthermore, it was deemed important to establish differentiated housing possibilities for the most deviant and disturbed group of patients.

It is recommended that the Community Mental Health Centres each have a catchment area of 50,000-70,000 inhabitants in order to provide a more differentiated variety of treatment and a greater flexibility. The Community Mental Health Centres should not be detached

from the psychiatric departments, since this may result in a lack of continuity of care for the individual patient. Furthermore, the Advisory Group sees no advantage in recruiting "support & contact persons" attached to the social services who may be without any professional background, since this may result in a new group of "helpers" being involved in the treatment of psychiatric patients.

Concentrating the community psychiatric treatment on patients with severe chronic psychotic disorders has the result of leaving patients with milder disorders without any community psychiatric treatment. Consequently, the availability of community psychiatric care is at present insufficient, and it is suggested that the city of Copenhagen should increase the total number of psychiatric beds and work towards an improved access to nursing homes for psychiatric patients needing constant institutionalization.

5 HOSPITAL PLAN YEAR 2000

The Hospital Plan of the municipality of Copenhagen (Sygehusplan H:S 2000, 1996) was completely reorganized due to a political decision to merge the three administrative bodies in charge of health services in the Copenhagen area; namely, the municipality of Copenhagen, the municipality of Frederiksberg, and the state. As a result the Copenhagen Hospital Corporation (H:S) was founded January 1, 1995, with the aim of providing an effective use of resources, easy and equal access to all facilities provided by the health services, health service on a high professional level, continuity of care, and respect for the citizens' personal integrity.

5.1 Psychiatric Services

The psychiatric services of the municipality of Copenhagen are now part of the Copenhagen Hospital Corporation. By the turn of the century the city will have five general hospitals, and each general hospital will have a psychiatric department providing

comprehensive psychiatric services for the inhabitants of the catchment area. The somatic and the psychiatric part of each hospital will have similar catchment areas. Each department will have a psychiatric emergency clinic providing services around the clock for all persons who contact the clinic. All treatment is free of charge.

Each department is headed by a chief psychiatrist and a chief nurse with overall administrative and budgetary responsibility for all psychiatric services, including community mental health services. The psychiatric hospital, Skt. Hans, will remain to a large extent unchanged.

6 THE PRESENT STRUCTURE OF SERVICES

In 1997 the psychiatric services of the Copenhagen Hospital Corporation have the following capacity:

Kommunehospitalet*	72 beds
Bispebjerg Hospital	99 -
Frederiksberg Hospital	96 -
Hvidovre Hospital	120 -
Rigshospitalet	75 -
Skt. Hans Hospital	531 -

The mental hospital comprised:

Organic brain disorders	132
Long term patients	134
Younger psychotic	114
Forensic patients	68
General psychiatric treatment	84

(* Following the establishment of the Hospital Corporation, the psychiatric departments at Kommune hospitalet will close down in the near future as the entire hospital closes down, and the department will be transferred to the new Amager Hospital that is to be established.)

Presently, the city is fully covered with community psychiatry with the following community mental health centres:

Hospital:	Centre:	Borough:
Kommunehospitalet:	Indre by Amager	Indre By Christianshavn Sundby Nord Sundby Syd Amagerbro
Bispebjerg:	Brønshøj Bispebjerg Ydre Nørrebro Ydre Østerbro	Brønshøj Bispebjerg Ydre Nørrebro Ydre Østerbro
Frederiksberg:	Frederiksberg	Frederiksberg
Hvidovre:	Valby Vanløse Vesterbro	Valby Vanløse Vesterbro
Kgs.Enghaveig Hospitalet:	Møllegade Indre Østerbro	Indre Nørrebro Indre Østerbro

6.1 Referral to Services

The referral to the emergency clinic may take place through all sorts of agencies, or by the patient him- or herself. No formal referral is needed and the emergency clinic has to provide acute psychiatric care to all those contacting the clinic, irrespective of their residence.

Similarly, at the community mental health centres no referral is needed, and any citizen may come and ask for psychiatric help. Services are available during normal working hours; outside working hours patients have to contact the emergency clinic.

Patients are usually referred for treatment from general practitioners, specialists in psychiatry or other hospital departments. More than 90% of all referrals to in-patient care are acute - and will typically follow a psychiatric assessment at the emergency clinic. The department has to accept all referrals from the catchment area.

Standard of care: Each department provides a variety of services including both open and

locked wards; possibilities for day-patient care and out-patient treatment. The treatment modalities offered comprise psychopharmological treatment, psychotherapeutic treatment, and milieu treatment as the most prevailing ones. Each department has multi-disciplinary teams responsible for treatment, including psychiatrists, psychologists, social workers, physiotherapists, occupational therapists, and nurses.

The catchment area of each department is fully covered with community mental health centres. These centres are located centrally in the catchment area, which may comprise between 25,000 - 90,000 inhabitants.

6.2 Liaison Psychiatric Services

At all the general hospitals an extensive liaison psychiatric service takes place. Typically one or more specialists in psychiatry focuses on this task and carries out psychiatric consultation to the different departments. Regular conferences may take place with, for example, child psychiatric units, pain clinics, neurological units, burns units or other specialities needing frequent psychiatric expertise.

6.3 Community Mental Health Service

Each Community Mental Health Clinic has a multi-disciplinary team headed by a psychiatric consultant and a chief nurse, with the same professional groups as in the hospital department, and is under the administrative responsibility of the department. The community clinic typically provides out-patient care, to some extent day-care, and carries out assessment interviews for referrals from the catchment area. Typically, the community clinic may offer extensive out-going services with home visits, working with the social support system and close collaborating with primary health care and social services. There is a close collaboration between the community clinic and the in-patient department with various kinds of joint patient conferences, educational programs, rotation of staff, etc. On an individual patient basis, staff members collaborate in relation to case management to ensure optimum continuity of care.

6.4 Forensic Services

As all departments have comprehensive responsibility, they receive forensic patients, transferred from prisons, police stations, etc., or patients having a sentence with a psychiatric condition. The psychiatric hospital has a special ward for forensic care, primarily for psychiatrically sentenced patients needing long term admission. It has recently been concluded (Rapport, 1997) that in order to solve the present problems with the increasing number of forensic patients, an increase in the bed capacity for this patient population is required. It is recommended that forensic psychiatry is primarily concentrated in the psychiatric hospital, where further locked wards should be established.

6.5 Patients with Problems of Abuse

i. Alcohol abuse:

Alcohol represents a major problem in the city of Copenhagen. Previously, patients with alcohol problems were frequently admitted to psychiatric departments. Over the last decade, a significant decrease in the number of admissions with alcohol related disorders has been observed. This is partly due to the fact that the emergency clinics at the psychiatric departments in Copenhagen provide treatment for withdrawal symptoms without admitting the patient. Only a small proportion of patients showing psychotic symptoms or very disturbed behaviour will be admitted to psychiatric departments. Patients with alcohol problems, who do not require admission, may receive treatment in various settings. Related to all hospitals are alcohol clinics with interdisciplinary teams which provide medical and social help to patients with alcohol disorders. A large number of other clinics exist using different treatment models. Among these the following could be mentioned: Alcoholics Anonymous, Blue Cross, Minnesota model, and several types of private clinics. There is very limited collaboration between the different agencies providing care for patients with alcohol problems. This makes it difficult to get an overall view of the size of the problem and an evaluation of the services provided.

ii. Drug Abuse:

The treatment of drug addicts has traditionally been placed outside the health services. In Copenhagen the social services have established a number of local district centres to take care of this population. Generally, patients with substance abuse will get in contact with psychiatric services if they have a dual diagnosis of substance abuse and a psychotic disorder, or if they manifest suicidal behaviour.

6.6 Initiatives according to Hospital Plan

It is specifically mentioned in the plan that psychiatry will receive top priority. Among the necessary initiatives to take place are the following:

- The present capacity of psychiatric beds is inadequate and increased resources have to be allocated to psychiatry.
- The number of psychiatric beds in acute and general psychiatry will be increased by about 50 beds.
- Community Mental Health Care will be further expanded and the whole Copenhagen area will be covered with community psychiatric care.
- Catchment areas of somatic and psychiatric departments will be identical.
- The facilities for the psychiatric departments will be improved. This implies that any department establishing new beds will provide single room facilities for all patients, and departments already established will be transformed into single bed units by the year 2002.
- A limited number of rooms providing two bedroom units will still exist to satisfy a specific wish for some patients.

7 PROVISION AND UTILIZATION OF PSYCHIATRIC SERVICES

7.1 Provision of beds

In 1976, **Denmark** had approx. 2.4 psychiatric beds per 1,000 inhabitants. In total, the

number of psychiatric beds amounted to about 10,000. In 1987 about 2,600 beds were adminstratively transferred to social services, as they were placed in gerontopsychiatric nursing hospitals that were taken over by the social services. Consequently, the number of beds decreased from the 2.4 per 1,000 to 1.2 per 1,000 in 1987.

The Ministry of Health and the Ministry of Social Affairs (Sundhedsministeriet & Socialministeriet, 1993) reported that the development of beds per 1,000 inhabitants in Denmark during the period 1989 - 1993 decreased from 1.0 to 0.8 per 1,000 inhabitants. Since then, the total number of beds has decreased by a further 5% to the present (1995) figure of 4,065 beds in all psychiatric institutions (Institute of Psychiatric Demography, 1995).

The number of psychiatric beds per 1,000 inhabitants in **Copenhagen** reached a peak in the late 1970s, when Copenhagen had about 7 psychiatric beds per 1,000 inhabitants. However, at that time the city also partly provided mental health care for the municipality of Frederiksberg and a neighbouring county. Due to the administrative change in 1987 the number of psychiatric beds in the city was reduced to 3.1 psychiatric bed per 1,000 inhabitants.

In the municipality of Copenhagen the number of beds in 1989-1993 decreased from 2.3 to 1.8 per 1,000 inhabitants, and in the municipality of Frederiksberg (now part of the Copenhagen Hospital Corporation) the number of beds increased from 1.0 to 1.1 per 1,000 inhabitants. At the establishment of Copenhagen Hospital Corporation, the number of beds was approx. 1.7 per 1,000.

7.2 Utilization of services

Concomitantly with the reduction in the number of beds we have experienced a reduction in the number of long-stay patients. Furthermore, we have observed that the **average number of days per admission** in **Denmark** declined from 48 in 1989 to 40 in 1992. During the same period the annual number of admissions did not decline but remained relatively

constant at around 35,000 - but with a change in the diagnostic distribution, as the number of admissions of schizophrenic patients has increased, whereas a decrease has been observed in the admission of patients with neurotic disorders.

In the municipality of Copenhagen the average length of stay fell from 71 days in 1989 to 39 days in 1993.

According to the Danish National Psychiatric Case Register (Institute Psychiatric Demography, 1995), all Danish psychiatric departments had 34,248 admissions (17,148 males and 17,100 females) and 33,912 discharges in 1995 (16,991 males and 16,921 females). Out of these, 4,895 (2,529 males and 2,366 females) were admitted and 5,936 (3,070 males and 2,866 females) were discharged from all the psychiatric departments in the municipality of Copenhagen. Further, 1,593 (1,050 males and 543 females) were admitted and 1,606 (1,054 males and 552 females) patients were discharged from the psychiatric hospital Skt. Hans. Whereas the country as a whole, and the acute departments in Copenhagen, observed almost similar numbers of male and female admissions and discharges, males comprised 66% of both admissions and discharges from the psychiatric hospital. This male preponderance was particularly pronounced at the forensic ward and the ward for patients with various kinds of abuse.

The **consumption of hospital days** in Copenhagen has been more than halved during the period 1970-84. The reduction in hospital days is found in all age groups, but in particular among the middle aged and elderly. Further, psychiatric patients up to the age of 45 in 1984 consumed about 50% of the total number of hospital days, and over the years this age group in absolute numbers has had a rather constant consumption of hospital days (Direktoratet, 1987).

Copenhagen had in the same period experienced a reduction in the population by 23%. In the light of this, it was stated in the Psychiatry Plan (Direktorat, 1987) that the steep reduction in psychiatric bed days for the middle aged and elderly was due to a combination of demographic factors, the increased emphasis on out-patient treatment and day hospital

treatment, together with the fact that a number of these patients (in particular those with organic brain disorder) had been transferred to the social services.

The reduction in bed day consumption for the younger age group was related to an altered treatment ideology, which placed emphasis on out-patient treatment and short term in-patient episodes.

With a regard to **diagnostic groups**, the reduction in hospital days is found in all the main diagnostic groups, but particularly organic disorders and reactive disorders (including personality disorders), alcohol and substance abuse and neurotic disorders, while the 2 largest diagnostic groups with regard to consumption of hospital beds are now, as previously, schizophrenics and patients with reactive disorders.

Out-patient care, on the other hand, has increased in Denmark, where 53,544 (23,045 males and 30,499 females) started day- or outpatient treatment in 1995. In Copenhagen, 7,410 (3,586 males and 3,824 females) started day- or outpatient treatment in 1995. Of these, 1,414 (717 males and 697 females) started treatment in the community mental health clinics, which corresponds to 26% of all day- or outpatient treatment started at the psychiatric departments in Copenhagen. **Community psychiatric services** are now available for about 80% of the Danish population, but with regional variations from 20% to 100%.

The Psychiatry Plan concluded (Direktoratet, 1987) that the demographic development, the development in treatment methods, the change towards increased day hospitals and extramural activity and the establishment of community mental health centres could be expected to reduce further the need for psychiatric hospital beds in the years to come. Further, it also concluded that a reduction is likely to be seen in the use of psychiatric beds even for the younger age groups.

7.3 Staff

Based on figures from the largest department in Copenhagen, the staff related to psychiatry in 1997 was calculated showing per 1,000 inhabitants:

0.3	doctors
0.09	psychologists
0.1	social workers
0.06	physiotherapists
0.1	occupational therapists
1.0	psychiatric nurses
0.6	mental health assistants and other aides.

Of these: 0.08 doctors; 0.03 psychologists; 0.04 social workers; 0.02 physiotherapists; 0.05 occupational therapists; 0.1 psychiatric nurses and 0.01 mental health assistants and other aides worked in community mental health settings. Nursing staff are thus relatively less commonly working in community mental health compared in particular to social workers, occupational therapists and psychologists.

The number of staff in Copenhagen related to community psychiatry differed from the country as a whole. Denmark had 0.04 doctors per 1,000 inhabitants, 0.04 nurses and a total of 0.16 staff members per 1,000 inhabitants working in community mental health settings.

7.4 Physical facilities for psychiatric care

In 1996, the Ministry of Health carried out a questionnaire regarding the physical facilities at the various psychiatric departments in Denmark, as a consequence of the agreement between the government and the regional health authorities to allocate increased resources to mental health, and in particular to improve the physical facilities of the various psychiatric institutions. The survey showed for Copenhagen an average of 14 **beds per ward**. Of all beds 48% were located at open wards, 19% at locked wards, 12% in long-term care, 7% in forensic care, and 5% in gerontopsychiatric units. Single rooms were

found among 30% of all beds, ranging from 20% in the open wards to 59% in long-term wards. 49% of all beds were located in rooms with 2 beds and the remaining 21% in rooms with more than 2 beds.

Copenhagen had relatively fewer single rooms, as the whole country had 42% of beds located in single rooms, 45% in 2 bed rooms and only 12% in rooms with more than 2 beds. The number of available toilets and **bathrooms** were calculated and showed that each ward in Copenhagen had on average 2.4 toilets, 1.0 bathrooms and 1.6 combined toilet/bath. Less than 1% of the rooms had their own toilet or bath. The availability of sanitary facilities did not differ from the country as a whole.

The availability of **other types of facilities** was analysed, showing that in Copenhagen 79% of all wards provided the patients with a sitting room, 90% with dining facilities, 21% with separate rooms for smokers and 33% with non-smoking facilities. Music or TV rooms were available in 20% of the cases, and visiting areas in 30%. Here again no difference was observed with regard to these facilities from the country as a whole. In Copenhagen access to **out-door facilities** was available in 49% of the wards. In 41% of the cases the wards could only provide non-secure out-door facilities, and in 26% the department could provide secured out-door facilities. In the country as a whole 83% of all wards had some kind of availability of out-door facilities. Thus, we see that Copenhagen differs significantly with respect to this. The vast majority (78%) of the departments in Copenhagen were located in **buildings** dated back before 1950. However, only 10% of them had not undergone any reconstructions. It is characteristic that all locked departments had undergone some kind of reconstruction since 1950.

Access to various **therapeutic facilities** was highly prevalent. In Copenhagen, 90% of wards had access to physiotherapy and gymnastics, 93% to occupational therapy, 90% to kitchen training and 86% to various kinds of workshops. Compared to the country as a whole there was easier access to all facilities in the Copenhagen area.

7.5 Free hospital choice

According to Danish legislation, citizens have a free choice with regard to basic hospital care. This implies that psychiatric patients may ask to be treated at any psychiatric department, according to their choice, and that the department cannot refuse to provide services free of charge. In practice it has, however, turned out that this right has not been used by many citizens, and that at any given time only a few percent of the admissions in Copenhagen are due to a specific request to be treated at a given department, whereas the vast majority get treated at their regional psychiatric department.

8. ROLE OF USERS AND RELATIVES

Several organizations exist in Denmark which represent the interests of users and relatives. It is characteristic that these organizations have been able to lobby effectively for the rights and influence of users and relatives. These organizations have developed alternative models for the provision of psychiatric care, and have been successful in obtaining political contacts. The relation between these consumer organizations and institutional psychiatric care is to a large extent based on personal contacts and less on formalized collaboration.

In Copenhagen, however, a number of psychiatric departments have established relative groups, psycho-educational groups, open counselling, and so on. In the Community Mental Health Centres there is a formalized collaboration, as each centre has a **"consumer council"** with representatives from users, relatives and staff, who together discuss issues such as the various activities offered, and the facilities available. According to the Danish Mental Health Act it is also mandatory for psychiatric departments to have open **"patient meetings"** on a regular basis between the head of the department and patients admitted, to discuss the quality of services, availability of therapy and activities, etc.

There is an increasing recognition among professionals that the influence and feed-back from consumers has been insufficient up till now, and that psychiatric services could benefit from an increasing influence from such groups.

9. IMPLICATIONS

We are presently witnessing different developments in the organization of mental health services.

In some regions of Denmark, out-patient and community psychiatric care have been **taken over by social services,** with a consequent decrease in the medical impact, whereas other regions - among them Copenhagen - have established community psychiatric services with a clear medical responsibility.

Psychiatrists generally agree that the **key population** for psychiatric care is the chronic psychotic population. As a consequence, large groups of patients with less severe disorders (e.g. milder depressions, traumatic reactions, stress related disorders) are treated outside institutional psychiatric care, frequently by G.P.s or psychologists. Other groups, e.g. patients with problems of abuse, are receiving treatment at special institutions. If this development continues further, we may end up having psychiatrists with a highly specialized, but rather narrow, expertise. It is questionable whether this is beneficial for the profession in the long run.

We are experiencing in some areas a movement towards **demedicalization** of psychiatric care. The same **deprofessionalization** is seen where psychiatry has been administratively transferred to the social sector, thereby removing the psychiatric discipline from other medical disciplines - a development towards which the Danish Psychiatric Association has been critical. Related hereto, we experience a layman's wish for deprofessionalization and an interest among paramedical groups in the less severe disorders.

One way to fight this development, and join forces instead, could be to allow the consumers of services greater impact, and draw upon their experiences in the professional work.

The city of Copenhagen has avoided this development. It has constantly worked on the

principle that psychiatry is a medical discipline, and that psychiatric services are an integral part of the general medical services, with clear responsibility to provide the best therapy available consistent with accepted scientific knowledge and ethical principles, and to carry out research and evaluation in order to improve the quality of care and availibility of the most up-to-date treatment to the citizens.

REFERENCES

Direktoratet for Københavns Hospitalsvæsen (Directorate Copenhagen Health Services). Forslag til psykiatriplan for Københavns Kommune 1988-2000. (Proposal for a psychiatry plan for the municipality of Copenhagen 1988-2000. Copenhagen: Direktoratet, 1987.

Institute of Psychiatric Demography. Annual Statistics, 1995.

Knudsen HC, Jessen-Petersen B, Klitgaard V, Krasnik A, Nordentoft M, Sælan H. Distriktspsykiatri i København. En evaluering af de første to år. (Community psychiatry in Copenhagen. An evaluation after the first two years). Copenhagen: Institute of Social Medicine, Copenhagen University, 1992.

Københavns kommunes lægeråd (The Medical Advisory Board of the municipality of Copenhagen). Lægerådets kommentarer til psykiatriplan 1993 for Københavns Kommune. (Report by the Medical Advisory Board to the Copenhagen psychiatry plan of 1993). Copenhagen: Sundhedsdirektoratet, 1993.
Sundhedsdirektoratet (The health directorate). Psychiatry plan for the municipality of Copenhagen. Copenhagen: Sundhedsdirektoratet, 1993.

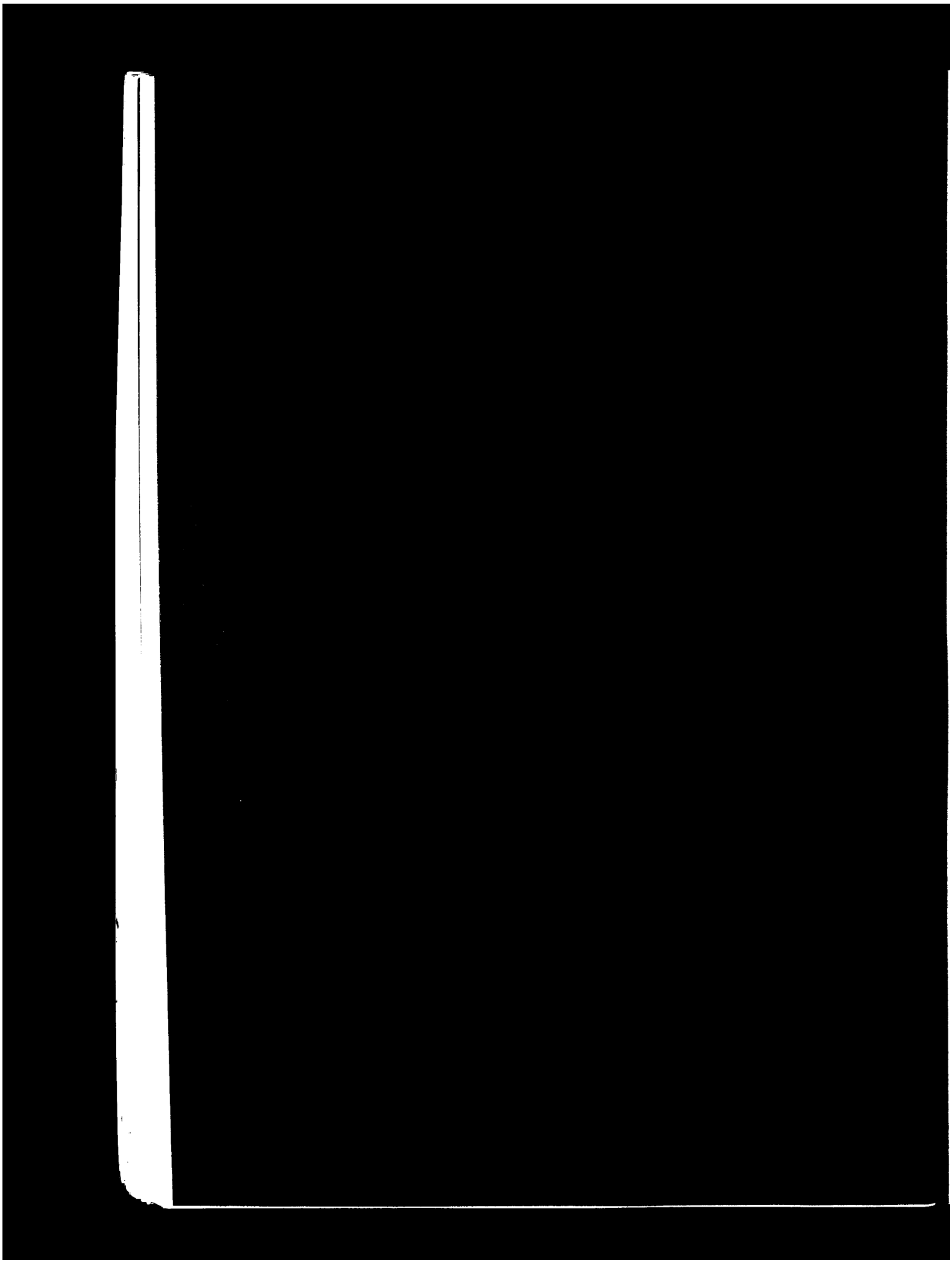
Rapport fra arbejdsgruppen vedrørende retspsykiatri i H:S (Report from the workshop regarding forensic psychiatry in Copenhagen Hospital Corporation). Copenhagen: 1997.

Sundhedsministeriet & Socialministeriet (Ministry of Health, Ministry Social Affairs). Fremrykning af indsatsen for sindslidende. Copenhagen: Sundhedsministeriet & Sundhedsministeriet, 1993 .

Sundhedsministeriet (Ministry of Health). De fysiske rammer på de psykiatriske afdelinger i Danmark. (The physical conditions of the Danish psychiatric departments). Copenhagen: Sundhedsministeriet, 1997

Statistical Yearbook for the Copenhagen Region. 1995.

Sygehusplan H:S 2000 (Hospitalplan Copenhagen Hospital Corporation Year 2000). Copenhagen: Hovedstadens Sygehusfællesskab, 1996.



CHAPTER 5

MENTAL HEALTH IN THE CITY OF KOBE, JAPAN

N Shinfuku[1], Susumu Sugawara, Teruo Yanaka and Mariko Kimura

(1) N Shinfuku
Professor in International Health and Epidemiology
Kobe University School of Medicine
Kobe, Japan

Tel: 81 78 341 7451

Fax: 81 78 361 1241
81 78 371 5171

CONTENTS

1. THE CITY OF KOBE, JAPAN

1.1 Population and other general outlines

Kobe city is situated in the Kansai area, close to Osaka and Kyoto. It is the prefectural capital of Hyogo Prefecture (population: 5.5 million) and with a population of 1.5 million, is ranked as the 6th largest city in Japan. Kobe city was one of two ports opened for foreigners after the Meiji Revolution which took place about 130 years ago, and was subsequently developed as major port in western Japan. Because of this historical background, the city is famous for active international relations. Several heavy industries, including ship building, are located in the city. The city is served by Shinkansen, national railways, several private transport lines, and access to the airports is easy. Kobe and its surrounding cities host a number of prestigious national and private Universities and Colleges. Kobe University is the major academic institution in the area, with 11 schools and several research centres. The International Centre for Medical Research (ICMR) was established in 1979 at Kobe University School of Medicine to promote collaboration in medical sciences with Southeast Asian countries, and the WHO Kobe Centre was established in 1996. In short, Kobe city is one of the most attractive cities in Japan and rated as the most desirable city to live in. It is also the favourite place for domestic tourism, particularly among young women, due to its international flavour and its modern shopping arcades.

1.2 Health indicators

Health indicators in Kobe are similar to the average in Japan. The infant mortality rate in Japan is 4.2 per 1,000 births, which is the lowest in the world. The average length of life is 80-83 for women and 76 for men. Hyogo Prefecture is a relatively wealthy prefecture and the percentage of the population receiving the "Life saving scheme" from the Government (a measurement of poverty) is low. The homeless are almost non-existent in Kobe, and street children are unseen. Amphetamine abuse among members of a criminal syndicate

(Yakuza) and the abuse of stimulants among young school drop-outs are reported by the mass media. However, the extent of these problems is small compared to their magnitude in the USA and in European countries.

Kobe city has a relatively large foreign population (more than 1% of the total population) compared to other cities in Japan. A considerable number of traders from China, Europe, India and Korea settled in Kobe over the past one hundred years. Recently, resettlement of refugees from Vietnam started in the suburbs of the city.

1.3 The Great Hanshin Awaji Earthquake

Kobe city was an epicentre of the Hanshin Awaji Earthquake which devastated Hanshin Awaji area on the morning of January 17 1995. The earthquake killed more than 6,300 people and injured more than 40,000. Almost 247,000 houses were destroyed. More than 310,000 people lost their houses and had to stay in shelters. At present, almost 20,000 people are still staying in temporary houses built for victims. Kobe city lost almost 100,000 members of the population after the earthquake as a result of emigration to nearby cities which were unaffected by the disaster. Unemployment, economic difficulties, and long term health consequences are placing an enormous burden on the affected vulnerable population, such as the elderly and handicapped.

2. MENTAL HEALTH SERVICES IN KOBE

2.1 History of the Mental Health Services

The mental health service in Japan is unique in many respects. The majority of mental health service provision is covered by private mental hospitals. However, fees for psychiatric services at private psychiatric hospitals are covered by national insurance schemes, and the policies and programs of these hospitals are controlled by Government regulations. Psychiatric services, both public and private, are meticulously controlled

through the detailed financing schemes of the National Health Insurance. This has created a unique system which could be called "privately run public mental health services". The Mental health services of Kobe city are no exception.

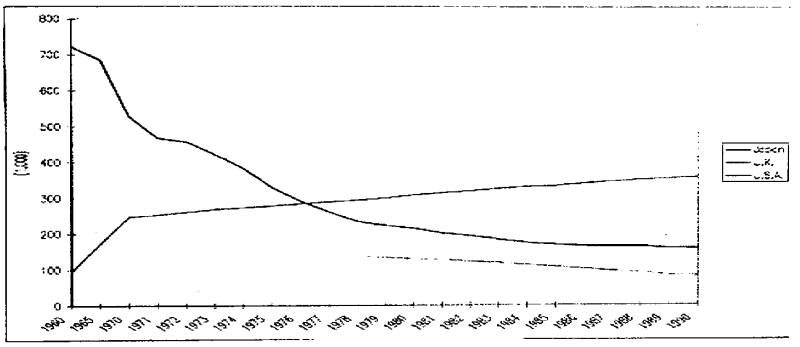


Figure 1 shows the change in the number of psychiatric beds in Japan, UK and USA from 1960 to the present time. This figure clearly indicates the contrasting trends of mental health services in Japan when compared with those in Europe and USA. In Japan, the number of psychiatric beds increased tremendously in the 1960s due to the Government policy of stimulating the building of psychiatric hospitals by the private sector. The number of psychiatric beds was 95,067 in 1960, and increased to 172,950 in 1965, 247,725 in 1970 and 268,669 in 1973. The rate of increase between 1973 and 1993 was more gradual, with the number of beds rising to a maximum in 1993 of 362,963. In 1994, the number decreased for the first time since the Second World War, to 362,235. This reduction was related to the gradual shifting of national mental health policy towards community care. At present, almost 90% of psychiatric beds are located in about 1,000 private psychiatric hospitals scattered all over Japan, each with an average bed size of between 200-400.

Although they are private psychiatric hospitals, fees for treatment (both inpatient and outpatients) are covered by National Health Insurance schemes. Therefore, private hospitals have been rather keen to keep as many patients as possible as long as possible for financial reasons. This system has resulted in a very long average length of stay of mental patients in Japan.

2.2 Budget for Mental Health Services

In Japan, the majority of health expenditure is covered by National Health Insurance schemes. Therefore, it is hard to identify the exact amount spent for mental health services. In the 1997 financial year , Hyogo Prefecture (5.5 million population) will spend $30 million on mental health and welfare services, out of its total health budget of $330 million,. This means that about 9% of the health budget of the local government will be spent on various programs and activities related to mental health and welfare services. However, this does not include medical fees for the majority of inpatients. These fees are mostly covered by National Insurance schemes or by the Government Life Protection scheme (for the poor). Kobe city has no separate mental health policy and program. The mental health policy and program of Kobe city constitutes a part of the mental health policy and program of Hyogo Prefectural Government in general. National mental health policy is decided by the Division of Mental Health at the Ministry of Health and Welfare in Tokyo, and the Mental health policy of Kobe city is in turn decided by the Mental Health Section of the Department of Health at Hyogo Prefectural Government. The author is a member of the Advisory Board of Hyogo Prefectural Mental Health Committee.

2.3 Main Features of the Mental Health Services

Different kinds of facilities and manpower comprise mental health services in Kobe city. Psychiatric hospitals and psychiatric clinics are major sources for the treatment and care of mental patients. There have been a growing number of private psychiatric clinics. The Prefectural Mental Health Centre at Kobe city focuses on promotion, prevention and education for health workers. It also organises day care services, and provides consultation services for patients. Local health centres are increasingly engaged in consultation and community services for mental patients. The Government is currently promoting the establishment of different kinds of community programs for chronic patients and elderly patients.

2.3.1 Different Service Providers

Psychiatric Hospital

In 1996, there were 42 psychiatric hospitals at Hyogo Prefecture. The total number of beds was 12,201.

These hospitals are categorised as follows:

Psychiatric beds at two University hospitals	=	60	beds
Two Prefectural Mental hospitals	=	605	beds
Psychiatric beds at Municipal hospitals	=	100	beds
28 Private Psychiatric Hospital Foundation	=	8,933	beds
9 Privately owned Psychiatric hospitals	=	2,503	beds
Total:		12,201	beds

In Japan, psychiatric hospitals have by far the largest resources in psychiatric manpower. Even a majority of community mental health programs are supported by staff members of psychiatric hospitals.

Table 1

Changes in number of psychiatric hospitals psychiatric inpatients

Year		Number of hospital	Number of beds	Beds per 10 000 pop.	Number Of Inpatients	Patients Hospitalised By Court order
1994	Hyogo Pref.	42	12,152	22.1	11,830	227
	Japan	1,672	362,235	29.0	343,126	6,408
1995	Hyogo Pref.	40	12,201	22.1	11,912	228
	Japan	1,671	362,180	29.0	340,785	5,905
1996	Hyogo Pref.	30	8,367	21.0	8,110	172
	Japan	1,667	361,053	18.8	339,762	5,436

* 1996 decrease is due to the Great Hanshin Earthquake.

Table 1 shows the number of psychiatric hospital beds in Hyogo Prefecture. However, there has been a decrease of psychiatric beds since 1995, due to the Great Awaji Hanshin Earthquake.

Psychiatric hospitals deal with patients with behavioural and emotional symptoms. Compulsory admission based on the Mental Health and Welfare Law is one of the major responsibilities of psychiatric hospitals. Public funds are provided for: the treatment of patients; hospitalisation under the medical protection scheme; and the compulsory hospitalisation scheme. Local Government support services relate to emergency psychiatric care. They collaborate with psychiatric hospitals in the community to develop rotational responsibilities for emergency care on holidays and at night time.

2.3.2 Psychiatric Clinics

The number of specialist psychiatric clinics is rather small - about 1,000 in the whole of Japan, and 92 in Hyogo Prefecture. However, the official number of psychiatric clinics in Japan is around 2,600, a figure which includes clinics run by internists and neurologists, who are permitted to treat mental patients. Although the number of clinics is small at present, this is the category of mental health service with the fastest growth-rate in Japan.

Due to the decrease of stigma attached to mental illness, more and more people are visiting psychiatric clinics. Also, national insurance schemes provide reasonable payment for outpatient treatment and day care services. This financing scheme is creating a favourable condition for psychiatrists to set up psychiatric clinics. Many young psychiatrists prefer to set up their own clinics rather than be employed by a private psychiatric hospital. The Government has realised that it is cost-effective to treat patients in the community rather than in hospital. In Kobe, several private psychiatric clinics were destroyed and closed after the earthquake.

2.3.3 Psychiatric Beds in General Hospital

Kobe University Hospital has a small number of psychiatric beds, and is used as a teaching hospital for medical students and post-graduate students. In Japan, very few general hospitals have psychiatric wards. However, an increasing number of general hospitals employ psychiatrists for liaison services, particularly for terminal cases.

2.3.4 Mental Health Centre

The Hyogo Prefectural Mental Health Centre was established in Kobe city in 1968, and plays a key role in mental health in terms of promotion, prevention and rehabilitation. It is also expected to provide technical guidance and support for mental health activities carried out at other Health centres. In Japan, mental health centres were established in the 1960s and 70s in each of the 46 prefectures. Hyogo Prefectural Mental Health Centre played a co-ordinating role in the provision of mental health care for victims of the Great Hanshin Awaji Earthquake.

2.3.5 Health Centres

Based on the guidelines of the Mental Health and Welfare Law and the Community Health Law, Health Centres (of which there are 852 in Japan, each having a catchment area of around 100,000 - 200,000 people) have been requested to play a co-ordinating role in the provision of mental health activities carried out in the community. Health Centres used to focus their activities on the MCH and anti-TB program, but changed their focus recently to concentrate on geriatric and mental health services.

2.3.6 Community Programs

In 1996, there were 98 occupational training centres, 33 short stay facilities, 79 welfare homes, 91 community vocational training facilities, 11 residential vocational training

facilities, 3 welfare factories and 22 community living support programs, all for mental patients throughout Japan. **Yadokarino-sato** is one of the pioneers of community living support programs for mental patients (see section 3.3).

Several of the above-listed community programs operate in Kobe and other parts of Hyogo Prefecture. The Government is planning both to increase the number and to promote the quality of these community programs as part of a "National Master Plan for Disabled Persons" enacted in 1995.

2.4 Payment

Table 2 shows the different payment schemes for mental health services at Hyogo Prefecture, Public Funds contribute the major part. National insurance schemes account for 60% of public funding based on Mental Health Law (involuntary hospitalization), life protection schemes, geriatric protection schemes and child protection schemes contribute another 40%. Very few cases pay privately for psychiatric service.

Table 2 **Changes in inpatient population**

(by financial support)

Type of financial support	**1994**	**1995**	**1996**
Mental Health Law	227	224	156
Life Protection Law	2,563	2,466	1,519
Others(Geriatric Protection Law, etc.)	2,539	2,540	2,202
Subdivisional Total	5,329	5,210	3,877
National Insurance	6,466	6,224	3,864
Private	3	1	0
Others	32	37	123
Total	11,830	11,472	7,864

(Hyogo Prefecture)

* 1996 decrease is due to the Great Hanshin Earthquake.

The total budget for the mental health program of Hyogo Prefectural Government is 3 billion yen (equivalent to approximately US $29 million). The majority of these funds are used to cover the treatment of patients admitted on Medical Protection schemes and involuntary hospitalisation schemes. These schemes are not covered by usual National Insurance schemes or by Life Protection schemes for the poor.

According to the report from the Hyogo Prefectural local government, the money will be used to support the following mental health and welfare activities for 1997:

1.	Community mental health and welfare program	=	34M ¥
2.	Rehabilitation of mental patients	=	297M ¥
3.	Geriatric mental health and welfare services including medical cost subsidy for patients under geriatric medical schemes. Without medical cost subsidy, the budget for the program is 19M ¥.	=	1,279M ¥
4.	Psychiatric inpatients treatment services including cost subsidy for medical protection and involuntary treatment	=	1,411M ¥
	Total:		3,021M ¥

Mental health activities used to be grouped under these four major headings, but after the Hanshin Awaji Earthquake, a new program of psychological care for the victims of disaster was added.

2.5 Patients

Table 3 shows the distribution of psychiatric inpatients in Hyogo Prefecture by diagnostic category. Schizophrenia accounts for more than 60% of inpatients. However, the number of geriatric inpatients has increased gradually.

Table 3

Changes in inpatient population

(by diagnostic criteria)

	1994	1995	1996
Schizophrenia	6,929	6,823	4,775
DM Disorder	614	558	329
Epilepsy	297	287	199
Geriatric M.D.	1,872	1,709	1,251
Alcohol & Abuse	630	608	298
Others	1,488	1,109	1,258
Total	11,830	11,472	8,110

(Hyogo Prefecture)

* 1996 decrease is due to the Great Hanshin Earthquake.

2.6 Staff

The number of psychiatrists in Japan in 1994 was around 9,512, or 4.3% of all medical doctors. The precise number of psychiatric nurses is not known. However, it is estimated that around 10% of all nurses are working in mental health services (around 80-90,000 nurses out of a national total of 862,013). In Japan, almost 20% (18.7%) of all hospital beds are psychiatric beds. Hospital services require a lot of nursing manpower. Occupational therapists are often in high demand, as their number is relatively small in Japan (7708 in 1994). As there is no specialist certificate for psychiatrists in Japan, no figures are available for numbers of staff or trainee psychiatrists. Also, there are very few posts available for psychologists in psychiatric services. The number of psychologists working in day-care services is increasing.

The demarcation of roles between hospital nurses, community nurses, and public health nurses has little meaning in Japan. Community mental health services, such as visits to patients in their homes, are carried out by hospital nurses in many cases. Also, public health nurses in the 852 Public Health Centres (Hokensyo) in Japan are increasingly

engaged in community mental health services, as their traditional activities such as vaccination and work on the anti-tuberculosis program have markedly decreased. Social workers and psychiatric social workers are not well established in Japan. The number of such staff operating in psychiatric services is still very small. The overall staffing figures per 100,000 people are as follows:

Medical doctors (all)	176.0
Psychiatrists	7.6
Nurses (all)	689.0
Mental Health nurses	60-70.0
Occupational therapists	6.2

The required number of medical staff working at medical institutions is determined by Japanese medical law. In psychiatric hospitals, the number of doctors and nurses can be reduced according to the nature of the care involved. In mental hospitals, a minimum staffing level of three doctors is required per 156 beds, compared to 52 beds in a general hospital. One additional doctor is required for every increase of 48 patients in a psychiatric hospital, while in a general hospital one additional doctor is required for every increase of 6 patients. A similar situation applies regarding the number of nurses. One nurse is required for every addition of 6 patients in a psychiatric hospital, compared with one nurse for every 4 additional patients in a general hospital. In Japan in 1994, an average of 2.5 doctors and 24.0 nurses per 100 beds were working in psychiatric hospitals, compared with 10.8 doctors and 42.7 nurses in general hospitals.

2.7 Co-ordination

The overall program is co-ordinated by the Mental Health Division of the Hyogo Prefectural Government, which is linked in with various mental health resources in Hyogo Prefecture, as well as with general health care services. Health and social services are well integrated, especially for geriatric mental health services. The Mental health centre has a

close working relationship with schools. Private and public psychiatric hospitals are obliged to work closely with the police for cases of involuntary hospitalisation. A combination of private and public services is available in the community for mental patients, as well as for the general population. In a unique way, this system seems fairly comprehensive and covers almost all the needs of the population of Hyogo Prefecture.

3. SOME RECENT POSITIVE FEATURES OF MENTAL HEALTH SERVICES IN KOBE

3.1 Increase of Private Psychiatric Clinics

In Japan, the majority of mental health services are run by the private sector, but supported by public money through the National Insurance schemes. This is particularly true in the case of private psychiatric hospitals. In line with the shift of national health policy towards community-based care, a number of policy changes have been introduced. One important recent development is the modification of national insurance schemes so that they favour community care. This has stimulated the opening of private psychiatric clinics in major cities. In Hyogo Prefecture, there are at present 92 private psychiatric clinics. These clinics began to be opened in the 1960s, and have gradually increased in number. Young psychiatrists interested in community care joined to open psychiatric clinics. Also, in the 1990s, the Government set a limit on the number of beds, including psychiatric beds, for each geographic medical service area. This has prevented psychiatric hospitals from increasing their bed capacity. The opening of new hospitals has become almost impossible. This situation has favoured the opening of many psychiatric outpatient clinics in the community. The gradual de-stigmatisation of mental illness has also undoubtedly played a major role in the increase of psychiatric outpatient clinics in Japan in recent years.

At present, the number of psychiatric clinics in Japan is around 1,000 - almost the same as the number of psychiatric hospitals. Private psychiatric clinics usually receive between 60

and 100 patients a day. Almost all patients are covered by national insurance schemes. Day care services are attached to some private psychiatric clinics. The image of private psychiatric clinics in the USA and in Europe, which portrays them as treating only the very rich using psychoanalysis, is very far removed from the private psychiatric clinic in Japan. The increase of private psychiatric clinics will surely be the most important feature in the development of community-based mental health services in Japan.

3.2 Consumer and Family involvement

Consumer involvement in medical services is poorly developed in Japan, partly due to the paternalistic and authoritarian nature of the culture,. However, the Association of Families of Mental Patients has played an important role in improving the quality of psychiatric care in Japan. Recently, protected workshops are run by the Association of Families of Mental Patients. Their number is increasing.

3.3 Yadokarinosato: Its Philosophy, Value, and Practice

3.3.1 History

Yadokarinsosato, (literally - "a home for hermit crabs"), was a project born out of social work in a private psychiatric hospital. In the late 60s, Teruo Yanaka, president of Yadokarinosato, was working as a social worker in a private mental hospital, engaged in the rehabilitation of inpatients in Saitama Prefecture. At that time, and even now, it is often the case that patients stay hospitalised for extended periods in Japan, compared to the average hospital stay in developed countries. This is due to a scarcity both of community support services, and of family members who can accept them at home. In 1970, Yanaka found a place for discharged patients to live upstairs in a factory, with the aim of turning it into a transitional house where discharged inpatients were sent to work for sheltered employment. However, this idea failed to gain approval, as the hospital authorities argued

that they might be blamed in the case of any accidents. In spite of this rejection by the hospital, and in addition to his work at the hospital, Yanaka rented the place for these patients to live, and began a housing program. This was the beginning of Yadokarinosato. When the hospital discontinued its day-care program, it was assimilated as part of the program at Yadokarinosato and make it into a "social club". During this period, staff lived with members, and provided support in preparing meals, life-skills training and finding sheltered employment. Later, this half-way house was closed due to the fear that it might create another institution. The focus of support then shifted to securing apartments, providing support in finding jobs in market employment, creating an environment for members to develop their own support networks among people with psychiatric disabilities, and organising a club for mental health consumers.

At present, Yadokarinosato has been approved as a corporate juridical body by Saitama Prefecture. As of February 1996, it holds 114 people with psychiatric disabilities. There are 26 full-time staff, including 16 social workers with the Bachelor of Social Work, one psychologist with the Bachelor of Psychology, several management staff, and 11 part-time staff. Programs provided by Yadokarinosato are described as follows: There are four sites called "Support Centres" in the southern part of Omiya city, each with a group home and a sheltered workshop. Each site also has three to four staff (sometimes just one), who are there to provide support services and case management. At one of these support centres, there is a meal preparation and delivery section. Meals are delivered to group homes and apartments of the members. There is a hostel near the Head Office which provides short stay, respite care, and transitional living services. The Head Office is responsible for the management and development of apartments. Recently, a new building was opened to set up a printing factory, and a Public Relations Office. Yadokarinosato also provides staff training programs for community mental health professionals.

3.3.2 Philosophy

It was Yanaka's idea to create a place for people with psychiatric disabilities separate from

the mental hospital, where members could feel a sense of belonging. The role of the staff is to provide support to complement the abilities and skills which have been lost as a result of mental illness and long-term hospitalisation. People with psychiatric disabilities require various kinds of support in order to live in the community. The focus of rehabilitation should be on the creation of various kinds of support around such people in order to make community living possible, rather than on the eradication of symptoms. In the process of building support around members, Yadokarinosato has demonstrated the importance of psycho-social aspects of support in the community, which have been different from those provided in mental hospitals.

1. Providing support so that they can live just like anybody else in the community.

It has been a service goal for Yadokarinosato to "allow persons with psychiatric disabilities to live an ordinary life". Yadokarinosato has accumulated data from practice in the community, and turned it both into written materials which describe the difficulties of community living, and programs which require further development by mental health professionals in Japan. This has formed part of the education of professionals, government officials and even physicians in the mental health field. The accumulated knowledge and methodology developed through practice in the community has provided a basis from which new principles of social rehabilitation and mental health policy can be formed. It has influenced policy makers in the mental health services in Japan to shift the focus of rehabilitation and funding away from the hospital-based medical model to a community-based model, since the reforms of Japanese Mental Health Act in 1987, when an article of social rehabilitation was added to the Act, and public funding increasingly began to be put into small-scale community programs. In this sense, the Act addressed the importance of the well-being of persons with psychiatric disabilities and the provision of support needed to realise community living, while the previous act addressed security and protection measures of the community from the mentally ill.

2. Providing a support for daily living.

Providing support for daily living is a way to normalise the lives of persons with psychiatric disabilities. Providing support includes building support networks and

communication between persons with psychiatric disabilities themselves, as well as the provision of support in areas such as management of medication, housing, and participation with other social activities in the community. Yadokarinosato also emphasised that it is important to obtain agreement between a consumer and a physician on the issue of medication: allowing a person sufficient medication to facilitate living in the community with some symptoms remaining; as opposed to being prescribed a dosage that renders the person dysfunctional, or concentrating efforts solely on the eradication of symptoms.

Yadokarinosato also presents a new concept of life for persons with psychiatric disabilities. Among rehabilitation professionals, social skills training was considered necessary for persons with psychiatric disabilities, and the goal is to allow such people to return to work in the open employment market. This goes against the traditional goal of rehabilitation for persons with psychiatric illness. Yadokarinosato introduced a new concept of social participation. This was to develop networks among persons with psychiatric disabilities, to enable them to feel empowered by sharing similar experiences of mental illness and hospitalisation. This gives a new meaning to the lives of persons with psychiatric disabilities, and expands the horizons and the definition of rehabilitation for them.

At Yadokarinosato, the goal for providing support is "living just like anybody else". The concept of "living just like anybody else" attunes to the concept of normalisation, and provides guidelines for how the professionals treat persons with psychiatric disabilities. Firstly, persons with psychiatric disabilities should be treated as ordinary people living in the community, rather than as a person with a psychiatric illness, regardless of their disability. In other words, "the person should be first, and the disability second". Secondly, we deal with a person who is responsible for their actions just like anybody else, regardless of psychiatric disabilities. In this sense, we ask a person to take responsibility for their actions, and we respect the person's decision. Thirdly, a person has the right to have his/her community living secured, and necessary support should be provided to make life in the community possible. Fourthly, leading an ordinary life in the community means respecting one's own decision to choose one's lifestyle, rather than having a mental health professional force a ready-made program on the person. By forcing a ready-made program

(such as skills training), there is a danger of assimilating persons with disabilities into one mode of training. While each has their own wish, and their own disabilities, the support required may differ. It is more humane to have an individualised program, creating one if necessary; and, sometimes, the support has to be tailored to individual needs.

3. Methodology of providing support for daily living.

Comparisons between the traditional medical model and the life model, upon which Yadokarinosato's program is based, have been made in various aspects of treatment.

Table 4 Comparison between the medical model and the life model

	traditional social rehabilitation (medical model)	providing supporting in daily living (life mode)
i) decision maker	helper (professional)	consumer
ii) responsibility	health care professional	decision by the consumer
iii) intervention	help to lead regulated life	help to allow the consumer to make one's own decision
iv) focus of treatment	diagnosis and symptoms	identifying areas where support is needed
v) relationship	treatment, helper and helpee	partner, and supporter
vi) focus of support	cure illness or correct incapableness	create supportive environment and programs
vii) principle	instructive and training-focused	interactive and supplemental support

Under the life model concept, six sub-concepts have been used to describe ways of helping:

First, if there is a sufficient variety of programs from which to choose, consumers can develop a sense of how to make their own decisions, based on the information provided by the staff.

Secondly, consumers decide which lifestyle they wish to adopt. The identification of support needed, decisions, and solutions to problems, are all conducted by the consumer through discussion with staff. This is contrary to the traditional "ladders" model of rehabilitation training.

Thirdly, the life model allows a person with psychiatric disabilities to live just like anybody else in the community. By providing support for daily living, the focus is not on guidance or training, but on creating services and programs which allow the person to be him- or herself.

Fourth, everybody has their own will, even though they might not be manifesting a strong motivation as a result of exhaustion from illness. Under these circumstances, it is important for the staff to wait for a person to make their own decision to choose a lifestyle. Staff have to respect that decision, and finds ways of offering support, so that wishes can be realised. In this sense, the staff work with users as partners.

Fifth, a person with psychiatric disabilities is not alone. They live within the network of persons with psychiatric disabilities, and thus feel supported.

Sixth, the life goal is to find ways in which to participate as a creative member of society through comradeship with those who share similar experiences of mental illness, or who could share similar values, rather than placing a strong stress on productivity. Through such encounters, one may find something worthwhile and significant to do in life.

3.3.3 Conclusion

Yadokarinosato has so far only served a small group of the population: 114 members, in the city of Omiya (population: 500,000) in Saitama Prefecture. Considering the scarce range of community support service programs that are currently offered, Yadokarinosato has provided an integrated service for its members to make community living for people with psychiatric disabilities possible for the past 25 years in Japan. Yadokarinosato has developed a support system by providing housing with support, consumers' support networks, and crisis intervention through case-management. The task is to develop a comprehensive support service system on a larger scale in the near future. We have argued that Omiya city needs one integrated service unit per 100,000 people. There is still a paucity of resources and support services in Japan, and a strong emphasis on mental hospitals, which limits the opportunities to bring about the community living of persons with psychiatric disabilities. While we expect the further development of community-based services for persons with psychiatric disabilities in Japan, in the present situation we have

to depend largely on volunteers. However, through building partnerships between mental health professionals, consumers, and volunteers, we may accelerate the process of normalisation, and make the community a better place to live for persons with psychiatric disabilities.

3.4 Mental Health and Welfare Program in General Hospitals

Health Centres are becoming more and more involved in mental health activities following the recommendation made by Ministry of Health and Welfare in January 1996. The recommendation asked Health Centres to play a central administrative role in the development of mental health and welfare programs in the community. The number and scope of the mental health programs available at a health centre depend on its resources and on the interests of staff members. A large number of staff members are public health nurses.

One of the most important programs carried out at health centres is education for families of mental patients. A recent survey revealed that out of 852 health centres in Japan 509 centres (68.9%) organised educational programs for family members of mental patients. In addition, 43 health centres plan to introduce family training programs in 1997. In Hyogo Prefecture, out of 41 Health Centres, 30 Health Centres (76.9%) organised family training programs in 1996. The content of these programs vary. The most frequent form is a monthly lecture to family members about the nature and treatment of mental disorders. 30% used the "Handbook for families of schizophrenia" developed by the Japanese Association of Families of Mental Patients. Social skills training was carried out at about 10% of centres. A more intensive psycho-education approach was carried out at 5% of centres. Almost 20% of centres had a structured program for family education. These techniques have been greatly influenced by research on families of schizophrenic patients, such as "Expressed emotion".

These developments at health centres should be perceived as positive steps to promoting

community-based psychiatric services in Japan. Mental health programs, including the family training program, are supervised by staff members of the Prefectural Mental Health Centre.

The Mental Health Centres and General Health Centres co-ordinate their care activities with psychiatric hospitals and private clinics.

3.5 Geriatric Mental Health and Welfare Services

Due to the sharp increase in the geriatric population, and changes in family structure, services for geriatric patients, particularly for senile dementia, have become the priority all over Japan.

Hyogo Prefecture has developed the following activities:

i Consultation on geriatric mental health - consultation activities with families with senile dementia at public health centres.

ii Financial support to geriatric care centres

iii Training for general physicians and public health nurses in the management of senile dementia.

iv Support to the inpatients rehabilitation facilities for senile dementia patients.

v Development of comprehensive community care systems for senile dementia; including health, medical treatment and social rehabilitation.

3.6 Psychological Care for the Victims of the Earthquake

Local industries were severely damaged by the earthquake, and many people who survived lost their jobs. Local Government quickly built temporary houses for 80,000 people. They gradually moved to public housing and houses built with the aid of low-interest loans. At

present, almost 20,000 people still live in temporary houses.

The impact of the earthquake was serious among the disadvantaged population, such as the elderly, who lost family, and who have no financial resources with which to re-build their houses. Soon after the earthquake, Hyogo Prefecture set up a **"Psychological Care Centre"** for the care of PTSD of victims of the earthquake. The centre has its own building, and recruited around 30 staff members consisting of psychiatrists, psychologists and social workers. The centre provides consultation services at Public Health Centres for victims with psychosocial problems, and services by mobile teams at temporary shelters and residences of victims.

Alcohol-related problems became serious among victims living in temporary housing. A special program was set up for the prevention and rehabilitation of alcohol-related problems among victims. In 1996, the centre received 9,516 consultations, including telephone counselling. The centre organised 97 lectures and meetings for health workers and victims to deal with PTSD and other psychological problems following the earthquake. Complaints of new cases of victims (3,851) included insomnia, anxiety, PTSD symptoms, depressive feelings, mood disorders, alcohol problems, hallucinations and delusions, behavioural problems, difficulties in interpersonal relationships and somatic symptoms. The Psychological Centre for the victims of disaster is unique to Kobe, and is expected to function for five years.

3.7 Residential Facilities in the Community

Rehabilitation facilities for psychiatric patients are poorly developed. The lack of rehabilitation facilities is cited as being the major factor contributing to the very long average length of stay for inpatients in Japan. Therefore, it was recommended to develop a number of rehabilitation programs to facilitate the discharge of long stay psychiatric patients, many of whom stay in hospital because they have no alternative place. Based on the policy of shifting the emphasis onto community care, the Ministry of Health made it a priority to increase the number of rehabilitation facilities in the community.

In line with Government policy, several activities to promote community programs have been initiated in recent years in the Kobe area. They are as follows:

i **Day care activities** at Prefectural Mental Health Centres.

ii **Social rehabilitation activities.** Support to 3 life skill training homes for discharged patients unable to lead an independent life. Each life skill training home has a capacity of 50 inmates, but actually accommodates 20-30 patients. There are only three life skill training homes in Hyogo Prefecture out of 99 in Japan at present.

iii Support to small scale **Occupational Workshops** run by Parent Association. There are 31 small scale workshops in Hyogo. The capacity of each workshop is around 10. At national level, the Government plans to increase its number from present 563 to 686 by the year 2002.

iv Support to **Group Homes.** Group homes are for discharged patients who are able to lead independent lives in the community. There are five in Hyogo. Each group home has 5-6 patients. At the national level, it is planned to set up 3 group homes of 5-6 patients for each health and welfare unit (300,0900 to 400,000 population). In Japan 920 group homes for 5,060 patients will be completed by the year 2002.

v Identification of and support for **Occupational Parents** for patients. For the rehabilitation and social integration of discharged patients, it is necessary to find industries who employ patients.

vi The rehabilitation program for discharged patients at a **Welfare Home.** There are 4 welfare homes for discharged patients in Hyogo Prefecture who are able to lead independent lives but unable to find homes after their discharge from hospital. Their capacity is around 10.

vii Support to **Parents Association and Alcoholics Anonymous.**

viii Support to **Psychosocial Rehabilitation Activities** for inpatients. National Insurance schemes pay less to long stay patients, but instead cover payment to rehabilitation programs at hospitals.

ix Issuing of **Mental Health and Welfare Card** to patients. The holder of the card can get several benefits, including the use of public transportation and other public services for free or for a reduced fee.

x **Training** of personnel in psychosocial rehabilitation.

Although there is increasing interest in setting up a variety of residential and non-residential

rehabilitation programs in the community, their number is very small when compared to the huge number of psychiatric beds in the hospitals. The majority of community rehabilitation programs are established privately with a subsidy from central and local government. In the majority of cases, the running costs of community programs are financially supported by the prefectural mental health program.

4. User's Organisation

Due to the strong stigma attached to mental illness, the involvement of Users in the planning and evaluating of mental health services is still in a very early stage. In 1992, the National Federation of Persons with Psychiatric disabilities was established. In Japan, consumer involvement in medicine in general is very poorly developed. Informed consent for medical treatment has become an important social issue in recent years. This is especially true of the mental disorders. The weakness of consumer involvement is based on the paternalistic cultural background. In Japan, good mental patients are viewed as patients who obediently follow the instructions of doctors and nurses.

In the field of medicine, equal partnership between service providers and service receivers is a long way from being achieved. Compared to the involvement of consumers, the Patients Family Association (Zenkaren) has been active and vocal. Zenkaren has contributed to the improvement of psychiatric care in Japan. Besides the user's organisation of mental patients, there are a few other consumer activities worth mentioning:

First is the movement of **Alcohol Anonymous (AA) Japan** which has a relatively long history. At present almost all prefectures have AA.

Second is the self help group of **Morita Neurotic Patients**. Morita neurosis is considered to be a kind of social phobia specific to Asian culture. The group is Called Seikatu-no-Hakken-Kai (Life Discovering Association). They have around 6,000 members and issue their own journals. They meet once a month to study principles of living skills, and to

exchange their experiences of adapting to their daily life. Morita therapy was developed by Prof. M Morita, a Japanese psychiatrist, about 80 years ago, based on his experience of curing his own neurosis. Morita therapy is said to be based on the living principles of Zen and Taoism.

5. SERVICE EVALUATION

Each Prefecture has its own local Mental Health Commission. Hyogo Prefecture Government has Hyogo Prefectural Mental Health Commission as an advisory body. Members include psychiatrists, professors, welfare officers, representatives of the Family Association and representatives of the Employers Association of discharged patients. The Commission has a mandate to protect the human rights of mental patients. It reviews requests for compulsory admission and medical protection admission. Also, the commission reviews requests for the discharge of patients, as well as the human rights of inpatients.

In 1989, the Ministry of Health and Welfare and the Japanese Medical Association developed a "Hospital Function Evaluation Manual" with a view to improving the quality of hospital services. This was adopted by the Japanese Private Psychiatric Hospital Association (Nisseikyo), and Nisseikyo prepared the "Psychiatric Hospital Function Evaluation Manual" in 1990. In 1993, a peer review was initiated by Nisseikyo. The review items included such items as "quality of service", "nursing care" and "patient satisfaction and security". So far, service evaluation is limited to inpatient services. The author is not aware of an evaluation scheme which will cover community care. This will be an area for further development in Japan, as well as in the Kobe area.

exchange their experiences of adapting to [illegible]

Prof. M Morita, a Japanese psychi[illegible]

curing his own neurosis. Morita [illegible]

and Taoism.

5. SERVICE EVALUATION

Each Prefecture has [illegible]

Government has [illegible]

Members include [illegible]

Assessment and [illegible]

Commission has a [illegible]

role is for [illegible]

service [illegible]

In 1980 the Ministry [illegible]

developed a "Hospital [illegible]

of hospital services.

Accreditation [illegible]

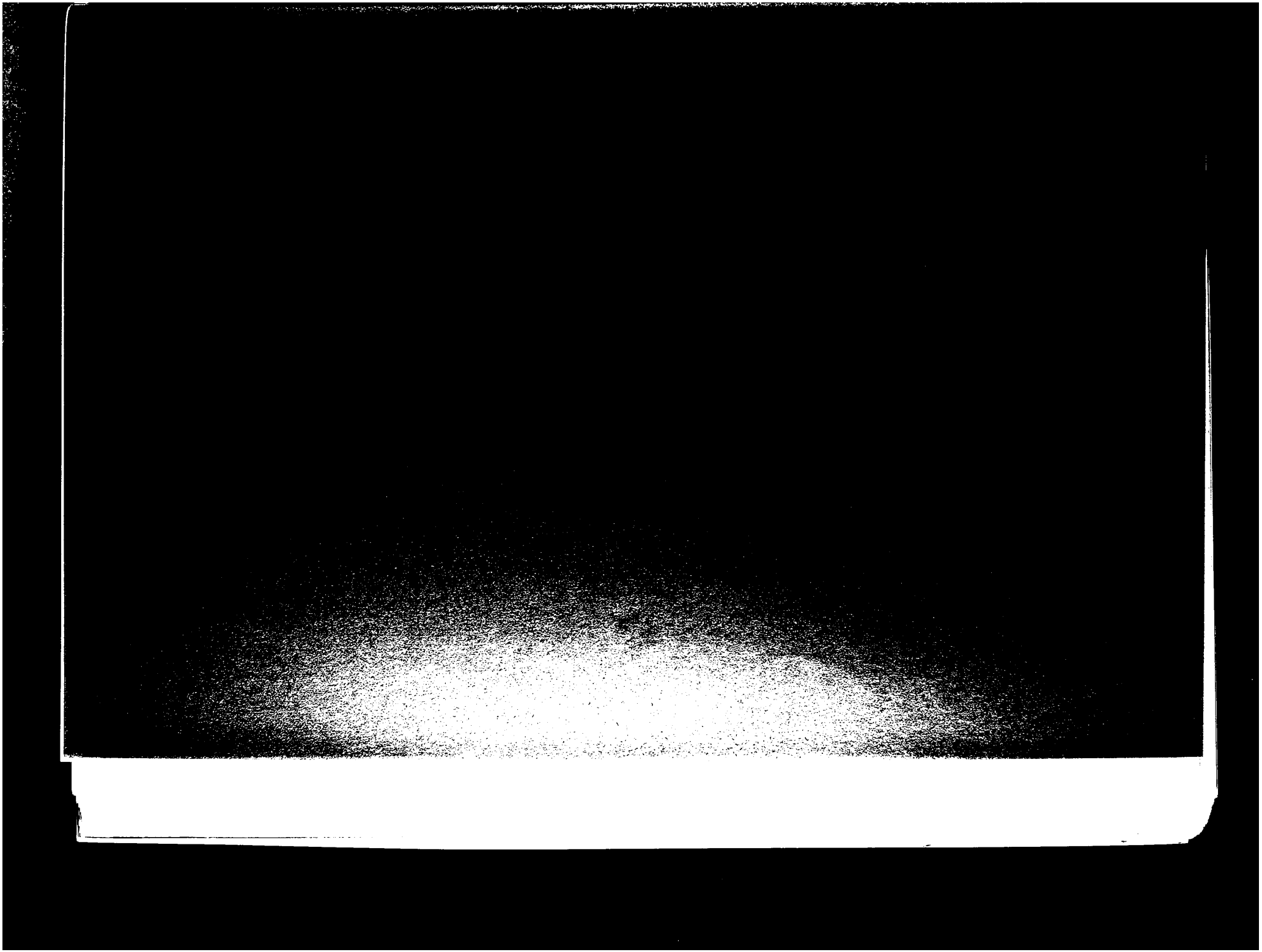
evaluation [illegible]

review teams [illegible]

satisfaction and [illegible]

author is not aware [illegible]

an area for further development [illegible]



CHAPTER 6

THE CITY OF MADISON, USA
The Madison Model : Keeping the focus of treatment in the community

David LeCount, ACSW

Dr David LeCount
Dane County Division of Adult Community Services
1202 Northport Drive, Madison
Wisconsin 53704, USA

Tel: 00 1 608 242 6468
Fax: 00 1 698 242 6531

CONTENTS

1. THE CITY OF MADISON, USA

The July 1996 issue of Money magazine ranked Madison, Wisconsin as the best place to live in America based on its vibrant economy (1.7% unemployment rate and plentiful jobs), excellent health care and educational systems, and low crime rate. In addition to being a great place to live and work, it is also a community that has a rich tradition of working together in solving problems. Madison achieved the highest ranking in health care, which is largely provided through four primary managed care companies called Health Maintenance Organisations. Located in south-central Wisconsin, Madison is home of the state capitol, and makes up approximately half of the 390,000 residents of Dane County. There exists an almost recession proof economy here because of the existence of the University of Wisconsin, Madison, and many governmental activities. A new state-of-the-art convention centre inspired by a Frank Lloyd Wright design, overlooking Lake Monona, opened in July 1997. Surrounded by plentiful lakes, dairy farms, and biking trails, the half-mile-wide isthmus with the Capitol at the centre is where the core public mental health programs exist in proximity to most of the consumers of mental health services. It is against this backdrop that the adult mental health system (Madison Model) has evolved over the past twenty-three years.

2. THE ADULT MENTAL HEALTH SYSTEM

2.1 The Madison Model

Another advantage of living in Madison has been the leadership role played by excellent clinical psychopharmacologic, community oriented psychiatrists in generalising research into practical application within the context of community-based treatment. While there has been resistance from the psychiatric profession in general to deinstitutionalizing patients because of risks and liability issues and an absence of responsible, community-based alternatives, in the community of Madison the concept of "the dignity of risk" has taken on great significance in the total evolution of the system. Psychiatrists have assumed the

primary leadership in the development and sanctioning of the Dane County (Madison) system. The senior psychiatrists have taught the psychiatric residents concepts of community psychiatry and interdisciplinary teamwork to maximise community integration. The Mental Health Centre of Dane County (MHCDC) has provided in vivo training in their core psychiatric programs for these residents. Many of these psychiatrists have continued to work in this model following their training, as well as carrying on the tradition in other parts of the country and world. We credit the contributions of community oriented psychiatrists with significant research findings and practical applications as well as pioneering approaches reflected throughout this report. Indeed, many of the primary philosophical principles that are a hallmark of this system have been developed and promoted by the seminal psychiatrists. As a result of the above, the dignity of responsible risk has taken on significant meaning in the "Madison Model." Community oriented psychiatry has carried forth and fostered this tradition into its present day form.

2.2 Programme of Assertive Community Treatment (PACT)

Since its inception in 1974, the adult mental health system administered by Dane County (Madison Model), has received widespread recognition and replication. From 1974 on, it has evolved to its current form, a comprehensive and integrated continuum of managed care for persons who have a serious and persistent mental illness. The Program of Assertive Community Treatment (PACT), begun in 1972, was a precursor to the core continuous treatment teams currently administered through the county's system of care. The PACT program demonstrated the efficacy of community-based treatment by 1978, and many of its proven treatment strategies have been generalised to the larger system in its present form. Since 1980, most of the Community Support Programs (CSPs) are now provided through the Mental Health Centre of Dane County's four programs serving 350 clients. As a state administered outpatient program, PACT continues to be a part of the Madison Model, representing one of the 40 programs currently under contract with the Dane County Department of Human Services. It provides services to 133 of the 1,537 clients who qualify as having the most serious and persistent mental illnesses. Additionally, many single

element programs continue to operate, but all are held together through contracted relationships, central entry points, and fixed case management responsibilities. Today the entire system of care is referenced as an integrated community support system.

The PACT program, as a pioneer and prototype model, is well known for demonstrating that in utilising a continuous treatment team, most clients can be stabilised and treated in the community, hence minimising the need for periodic and repeated hospitalisations. This program's control group, which receives primary treatment from the Dane County system, currently more closely approximates the results of the PACT program, particularly in regard to decreased levels of psychiatric hospitalisations.

PACT pioneered comprehensive and continuous community-based treatment referred to as Training in Community Living (TCL) of Continuous Treatment Team (CTT), for persons with serious and persistent mental illness. Diagnostically, these include schizophrenia, schizoaffective, major affective disorders, or severe personality disorders. Their research in using this model and comparing it to a control group focused initially (1972-1978) on people who were 18-62 years old. From 1978 to the present time, the age range has been 18-30 for persons with dual disabilities, substance abuse and serious and persistent mental illness. The control group has been primarily other Dane county public mental health system contracted services, which have become more refined over time (MMHI, Policy and Procedure Paper, Policy #4D.02)

Research findings are similar for all ages treated. Comprehensive, continuous assertive community-based treatment through TCL compared with the control group resulted in the TCL participants experiencing less use of hospitalisation, spending more time in independent living, manifesting fewer symptoms, having more involvement in employment, and experiencing a greater satisfaction with life (Stein L et al, 1975; Stein L et al, 1978; Test MA et al, 1978; Stein L et al, 1980; *Open Minds*, 1988; Test MA et al, 1996). In an earlier economic cost-benefit analysis study, it was concluded that the cost for hospital-based and community-based treatment were the same, $7,200 per patient per year (Weisbrod BA et al, 1980).

primary leadership in the development and sanctioning of the Dane County (Madison) system. The senior psychiatrists have taught the psychiatric residents concepts of community psychiatry and interdisciplinary teamwork to maximise community integration. The Mental Health Centre of Dane County (MHCDC) has provided in vivo training in their core psychiatric programs for these residents. Many of these psychiatrists have continued to work in this model following their training, as well as carrying on the tradition in other parts of the country and world. We credit the contributions of community oriented psychiatrists with significant research findings and practical applications as well as pioneering approaches reflected throughout this report. Indeed, many of the primary philosophical principles that are a hallmark of this system have been developed and promoted by the seminal psychiatrists. As a result of the above, the dignity of responsible risk has taken on significant meaning in the "Madison Model." Community oriented psychiatry has carried forth and fostered this tradition into its present day form.

2.2 Programme of Assertive Community Treatment (PACT)

Since its inception in 1974, the adult mental health system administered by Dane County (Madison Model), has received widespread recognition and replication. From 1974 on, it has evolved to its current form, a comprehensive and integrated continuum of managed care for persons who have a serious and persistent mental illness. The Program of Assertive Community Treatment (PACT), begun in 1972, was a precursor to the core continuous treatment teams currently administered through the county's system of care. The PACT program demonstrated the efficacy of community-based treatment by 1978, and many of its proven treatment strategies have been generalised to the larger system in its present form. Since 1980, most of the Community Support Programs (CSPs) are now provided through the Mental Health Centre of Dane County's four programs serving 350 clients. As a state administered outpatient program, PACT continues to be a part of the Madison Model, representing one of the 40 programs currently under contract with the Dane County Department of Human Services. It provides services to 133 of the 1,537 clients who qualify as having the most serious and persistent mental illnesses. Additionally, many single

element programs continue to operate, but all are held together through contracted relationships, central entry points, and fixed case management responsibilities. Today the entire system of care is referenced as an integrated community support system.

The PACT program, as a pioneer and prototype model, is well known for demonstrating that in utilising a continuous treatment team, most clients can be stabilised and treated in the community, hence minimising the need for periodic and repeated hospitalisations. This program's control group, which receives primary treatment from the Dane County system, currently more closely approximates the results of the PACT program, particularly in regard to decreased levels of psychiatric hospitalisations.

PACT pioneered comprehensive and continuous community-based treatment referred to as Training in Community Living (TCL) of Continuous Treatment Team (CTT), for persons with serious and persistent mental illness. Diagnostically, these include schizophrenia, schizoaffective, major affective disorders, or severe personality disorders. Their research in using this model and comparing it to a control group focused initially (1972-1978) on people who were 18-62 years old. From 1978 to the present time, the age range has been 18-30 for persons with dual disabilities, substance abuse and serious and persistent mental illness. The control group has been primarily other Dane county public mental health system contracted services, which have become more refined over time (MMHI, Policy and Procedure Paper, Policy #4D.02)

Research findings are similar for all ages treated. Comprehensive, continuous assertive community-based treatment through TCL compared with the control group resulted in the TCL participants experiencing less use of hospitalisation, spending more time in independent living, manifesting fewer symptoms, having more involvement in employment, and experiencing a greater satisfaction with life (Stein L et al, 1975; Stein L et al, 1978; Test MA et al, 1978; Stein L et al, 1980; *Open Minds*, 1988; Test MA et al, 1996). In an earlier economic cost-benefit analysis study, it was concluded that the cost for hospital-based and community-based treatment were the same, $7,200 per patient per year (Weisbrod BA et al, 1980).

In addition to the PACT research findings, the entire Dane County adult mental health system is now viewed as a national model of good community care (Stein L, Diamond R, & Facrot R, 1992). The most recent findings on the PACT control group, which is the Dane County system, is now more closely approximating the PACT program in terms of decreased hospital utilisation (Personal Communication from Test MA, 1997).

For many years the PACT program has had a work as treatment emphasis which is considered to be a crucial part of the psychiatric rehabilitation process. There are now seven vocational specialists in the PACT program and they have been able to maintain over 50% of their clients in competitive jobs (Russert MG, 1991; Frey JL, 1994). The next phase in the PACT research is to work with an even younger age range, 15-21. This is a logical progression in keeping with past emphasis on moving towards the earliest onset of the illness. They have concluded that some of the clients in their current group (ages 18-30) may have been identified earlier and with comprehensive treatment may not have lost functional impairment, due to being out of school , and by having better management of symptoms and reduction of episodic inpatient treatment (personal communication with J Frey, PACT principle administrator).

2.2.1 A National Community Support Training Resource Centre

For many years Dane County's system of care through the Mental Health Centre of Dane County was designated by the National Institute of Mental Health (NIMH) as a "National Community Support Training Resource Centre." Mental health professionals throughout the world have received training from the many programs in Madison. Mental health professionals from Dane County have also consulted nationally and internationally, and have received recognition for their innovative work. Thompson et. al. have concluded: "The success of the experimental clinical trials and imprimatur of NIMH have led many program planners to see the Madison Model of community care as a basic structure on which to build their own public mental health care systems. In addition, the experience of Dane County frequently serves as a reference point for measuring the achievements of

other systems of care" (Thompson, et. al., 1990, p. 625).

In 1984 the Dane County system received the National Association of Counties "County Achievement Award for Human Resources: Special Population Community Mental Health Services." In 1986 the Public Citizen Health Research Group (Washington D.C.) ranked the state of Wisconsin number one in the country for its provision of services to people who are seriously mentally ill. This ranking was primarily achieved because of the services provided in Dane County. E. Fuller Torrey, M.D. and Sidney M. Wolfe, M.D. stated in Care of the Seriously Mentally Ill, A Rating of State Programs: "Wisconsin has achieved a national reputation for excellent services for the seriously mentally ill primarily on the basis of the programs in a single county (Dane County) (1986, p. 48)." Since that time the Dane County adult mental health system has continued to make improvements through the provision of more comprehensive and better community-integrated services.

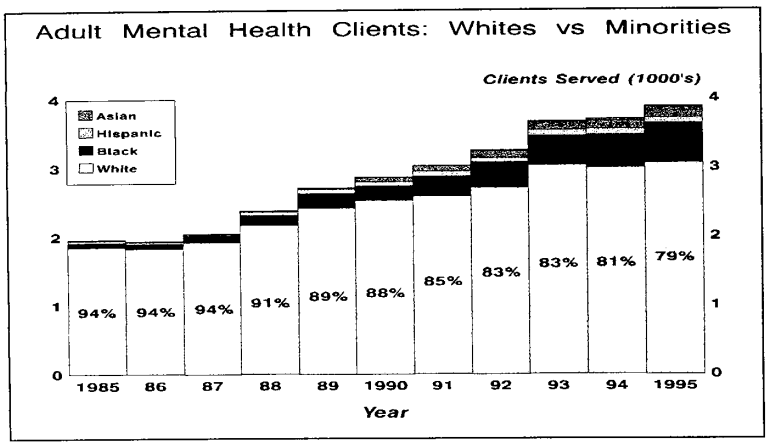
Ironically, even though the PACT prototype and the Madison Model have been widely studied, evaluated, and disseminated, there are many aspects of their programmatic success that remain unique and are not well publicised or understood. Since its inception twenty-three years ago, the Madison Model has maintained a focus on community treatment. The following highlights reflect how this emphasis has been maintained.

2.3 A Centralised Agency with fixed responsibility for total management and oversight

One of the most distinguishing features in the Dane County system is that the primary oversight of the entire public system is fixed in one central agency, which significantly enhances the ability to provide a well co-ordinated system of care. The Wisconsin State Statute dealing with disabilities, Chapter 51, was revised in the early 1970s to reflect the change from hospital to community as the focal point of treatment. This comprehensive legislation mandated that counties be responsible for the planning, development, budgeting, delivery, monitoring, and evaluation of mental health services relegated to the public

sector. Chapter 51 included a patient bill of rights section, specified that treatment occur in the least restrictive environment, and provided for a dangerousness standard and due process for involuntary treatment.

All court ordered services then became a mandated responsibility for the counties to implement and it required counties to pay for all services including inpatient treatment. Chapter 51 further specified that all services be authorised and statistically reported, tracked, and evaluated. Finally it changed the status of state hospitals



2.3.1 Target Population

Within a period of six years (1974-80), it became clear that the public sector's primary responsibility was to those most in need, requiring a system of care not previously available. The Alliance for the Mentally Ill of Dane County (AMI), which originated in Madison in 1977, provided an additional impetus in clarifying who should receive services. Today over 1,500 persons with the most severe schizophrenic and affective disorders receive the preponderance of the services, and another approximately 3,000 people receive more limited interventions. Many other people with dual mental health and substance abuse disorders and multiple disabilities are also the public sector's responsibility. The preceding chart shows the changing minority client composition, which is about ten percent higher in the mental health population than in the general population. Physical disabilities related to

the infirmities of ageing are rapidly increasing as the population grows older. Treatment of many disabilities are incorporated into the existing system directly, or as in the case of physical care, co-ordinated through the primary care physician in the private sector.

2.3.2 System Management

While the state legislation clearly fixes the responsibility with the counties to provide comprehensive services, each county has the option either to provide directly or contract out for the provision of services. Dane County has always elected to contract for services based on the cost savings this represents and the availability of well qualified existing private, non-profit agencies such as the Mental Health Centre of Dane County. Today there are 17 different agencies and 40 programs providing services through this contractual arrangement creating a public-private partnership. Through these contracted relationships central entry points are established; duties and responsibilities are defined; services then become authorised, monitored, and reported (Management Information System); and performance indicators are specified - all in an effort to meet the needs of the target population. System management functions are implemented in the following ways:

- The provider system has decentralised entry points to services, basing service delivery on the presenting need. Decentralisation is possible because each provider agency has identified with the entire system and operates in agreement with the basic tenets and service design of the entire system. The Emergency Services Unit (ESU) is the gatekeeper and authorisation agent for all psychiatric inpatient admissions paid for by the County. Supervised living arrangements, case management services, and Community Support Program (CSP) services, are all arranged through a separate Centralised Referral Exchange program. The only exceptions pertain to the PACT program, which does its own intakes following their prescribed research protocol, and ESU, which determines who is placed in their Crisis Home program. Work-related services are authorised at the county level in most instances. All other services are authorised by contracts based on statistical reporting to the County. In other words, many programs do their own intakes and determine whom to serve based on specified eligibility criteria written into their contract.

- Within each program, case managers are assigned to each client, with their duties and responsibilities clearly defined. If a particular client is involved in more than one program, the internal case manager spending the most time with that client is designated the system case manager, and acts as the primary co-ordinator of total programming for that client.

- At the county level there is a central tracking system that reviews the case management assignments to eliminate any duplication as well as to ensure that each client has a system case manager. Services that are mandated or court ordered are also tracked at the county level to ensure that required services are provided in a timely manner.

- Special features in the contract define service delivery expectations and how programs work together as a co-ordinated system of care.

- The Emergency Services Unit acts as gatekeeper to inpatient mental health services and also monitors all civil commitments and settlement agreements (court-ordered services) to assure treatment compliance.

- Corporation Counsel employed at the county level acts on behalf of the County in all involuntary court proceedings (civil commitment, incompetency/guardianship, and protective services/placements). The County's Adult Protective Services Unit is also involved as petitioner in the protective services process and monitors services in keeping with court orders.

- All contracted providers are required to report hours/days or units of services according to standard program categories (SPCs). Services must be reported that originate from the following programs: inpatient, day treatment, case management, community support program (CSP) services, community-based treatment facilities (group homes), adult family homes (foster care), crisis intervention, counselling/therapeutic resources (psychotherapy/psychotropics), intake and assessment, supported employment, and outreach.

- Performance indicators are written into the contracts, many of which relate to client satisfaction with the services received. The overall perspective in tracking outcome measurements from the entire system is to ensure that the following are met: (a) those clients most in need are given priority for comprehensiveness of services, (b) at least 80 percent of funding is maintained in community-based services, (c) per-person cost is monitored, (d) the average length of inpatient hospital stay is maintained or reduced, (e) 95 percent of clients reside in the community rather than in institutions, (f) persons in supervised living arrangements are monitored to keep these placements transitional with the goal of achieving more independent living, and (g) clients with paid work, including hourly wages and number of hours worked, are monitored.

- Intra-system and inter-system meetings are scheduled on a regular basis along with ongoing client system team meetings: to clarify roles, discuss client-specific issues, and identify system changes. This particularly happens around cases where there are issues that interface between systems such as with the criminal justice system, benefits procurement system, housing network, and emergency response systems.

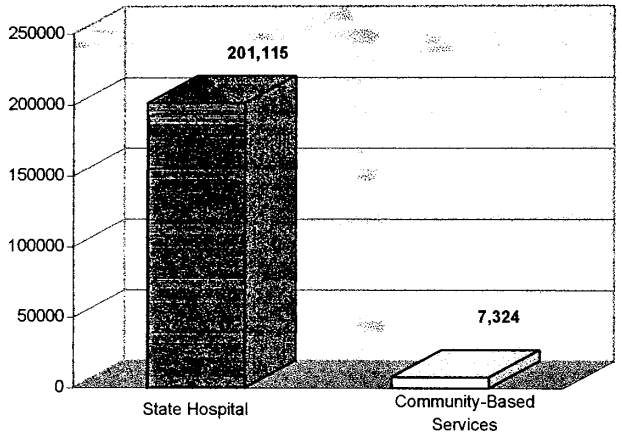
2.4 Cost and Clinical Effectiveness

The Madison Model has from its inception had to cope with limited funding and risk liability by developing a system of care that is both cost effective and clinically effective. A conscious guiding principle has been to emphasise concurrently therapeutic interventions that are effective, requiring the system to work in tandem with all related networks to maximise its efficiencies.

Every aspect of the system has been created and designed with the concept of cost effectiveness and clinical soundness in mind. As stated in an article reviewing the history of the Madison Model: "The ultimate stated goal of the system is to provide the least expensive mix of services necessary to enable each patient to live in the community, minimising patients' relapses while maximising their independence and quality of life" (Thompson, et. al., 1990, p. 630).

Most services were planned and developed with the assumption that community-based alternatives would reduce the need for high-cost inpatient services. In reality, it took until 1981 before this dream was realised. At that point, monies saved were realigned into community services. However, even with maintaining the average length of stay at 15 days over the past ten years, the cost of inpatient care at the state hospital has increased dramatically from a rate of $78 per day in 1978 versus $551 today. The present annual cost of care for one patient at the Mendota Mental Health Institute, (the state hospital located in Madison), comes to $201,115. With a current budget of $13,244,100 to serve 1,537 people who have serious and persistent mental illnesses, the average cost per person is approximately $7,324. The chart below shows that over a year's time, 27 people can be served in the community for the same cost as one person on an inpatient basis. While over 4,000 people receive some level of service in the adult mental health system, approximately 85 percent of the funding goes for services to people most in need and most severely impaired.

Cost Differential: Inpatient vs. Community



Contracting for services was a conscious decision made early on because of the numerous and well qualified private non-profit human service agencies already available in the Madison community. Studies indicated that in many instances the County can provide services at a reduced cost by outsourcing. The contracted system provides a wide range of cost-effective services throughout this stratified continuum in the following ways:

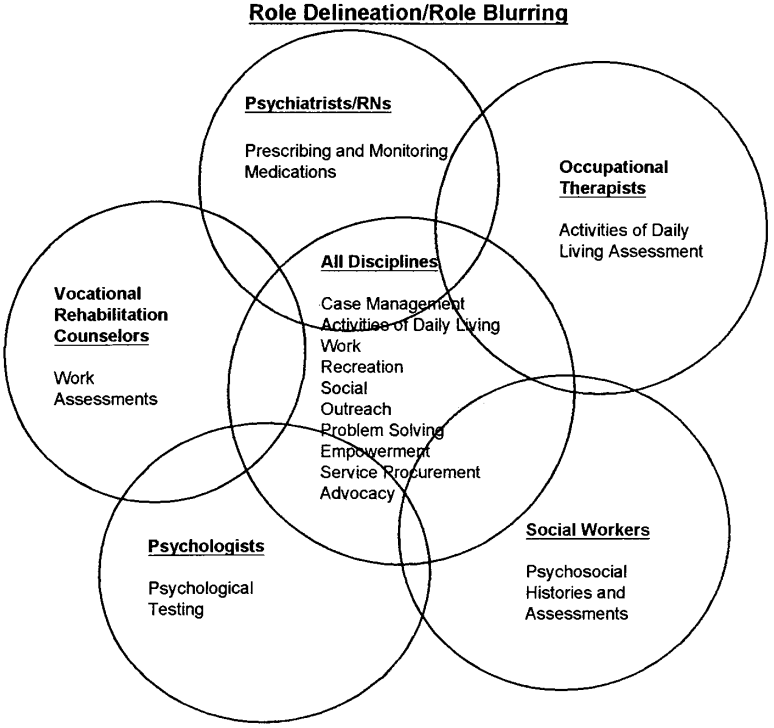
- The high cost institutional centres have been minimised. Core psychiatric services are provided through the Mental Health Centre of Dane County, and many other case management, work services, and programs that emphasised psychosocial and functional needs are being provided at a lower cost by other providers.

- As stated above, most of the community-based programs have been added over the years to reduce hospital utilisation, not only from a cost and treatment standpoint, but also because of client preference and to meet court-ordered requirements mandating the least restrictive treatment environment. The development of the Community Support Programs and supervised living arrangements has significantly contributed towards this end. For example, for one program alone, Crisis Homes, the co-ordinator estimated that 483 inpatient days had been avoided during 1996, achieving a net cost savings of $258,567 for the system.

- Due to the decline in number of private practitioners serving persons on Medical Assistance (a federal/state insurance program), cost-effective solutions were developed to provide more psychotropic drug services for persons unable to access the private sector. Over 400 additional persons gained access to psychotropic drugs with the creation of a separate medications unit, called the Medical Services Unit, at the Mental Health Centre, where nurses with R.N. degrees and psychiatrists efficiently serve

individuals requiring psychotropics. More recently an increase in the number of people receiving psychotropics has been achieved with psychiatrists consulting at family practice clinics (primary health care centres staffed by general practitioners serving low-income persons) and psychiatric residents providing a medications clinic at a homeless shelter.

Role Delineation/Role Blurring



- Role delineation is well defined in the system so cost effectiveness can be achieved with greater treatment efficiencies. Correspondingly, the concept of role blurring (generalists) has been incorporated into the subculture of the human services delivery system and related networks. While case management functions and psychosocial interventions within mental health cross many disciplines, there is a great amount of respect for the particular expertise that each profession brings to the treatment process. It is understood that specialised functions such as making diagnoses, performing psychological testing, prescribing psychotropic medications, ruling out nonpsychiatric medical issues, performing mental status exams, and assessing work/living/general functioning all require specialised training, expertise, licensure, and certification. Whereas helping clients learn new coping mechanisms and problem solving skills is not only relegated to the psychotherapist, but is a part of the everyday communication process with clients across all disciplines. Role delineation occurs in many ways. The work time of psychiatric personnel is always at a premium, and so it is used primarily

in a medically necessary and cost-effective manner. Psychiatric physicians, along with psychiatric nurses, focus on the psychotropic drug needs of clients. Psychiatrists complete psychiatric workups and make referrals to other medical specialities as needed. In addition to being consultants to treatment teams, psychiatrists also endorse and respect the roles of all other involved professionals. In the Emergency Services Unit, psychiatric social workers, nurses, and other personnel complete crisis assessments and involve a psychiatrist only as needed. Vocational rehabilitation counsellors may initiate work assessment and placement, with ongoing support being provided by the employer or another staff member. In some programs, occupational therapists take the lead in assessing Activities of Daily Living (ADLs) skills. However, all staff can assist in teaching skills for living successfully in the community. The following chart shows the number of staff by discipline per 100,000 population.

Staff by Discipline	Total	Per 100,000
Psychiatrists	**10**	**2.50**
Registered Nurses	**45**	**11.25**
Social Work and/or Related Master's Degree Staff	**70**	**17.50**
Licensed Psychologists	**3**	**.75**
Bachelor's Degree Staff	**80**	**20.00**
Non-Degree Clinical Staff (Mental Health Technicians)	**30**	**7.50**
Total	**228**	**59.50**

- Client (peer) support is being incorporated into the various facets of our treatment network on a paid and volunteer basis. Clients are employed in supervised living settings, the Emergency Services Unit, and Community Support Programs. A minimum of seven client operated organisations also function independently from the existing contracted system. Other self help peer support groups are incorporated into existing programs such as Yahara House. The AMI has numerous ongoing support groups for consumers and affected family members, and also provide educational programs such as "Journey of Hope." Consumers are involved in planning and hiring processes, and serve on provider boards and other decision making committees. Natural support systems are encouraged and supported throughout the system.

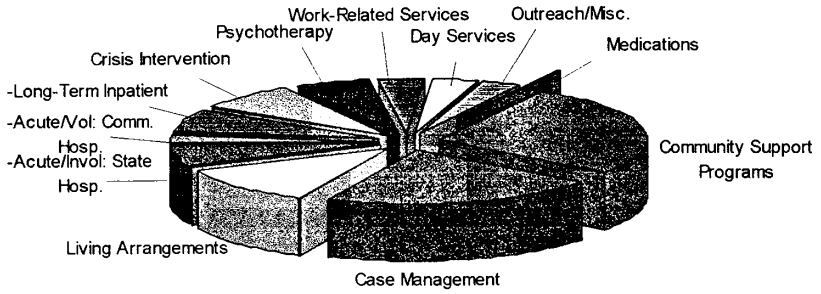
All of these factors provide services to more people at lower cost, fostering both effective treatment in the community as well as ongoing recovery.

2.5 A MATURE SYSTEM OF CARE

Deinstitutionalisation has been largely accomplished after many years, with over 95 percent of the clients now living in the community and receiving some degree of community-based services. Most of the county mental health clients reside in integrated scattered site apartments while receiving external supports. As a result, they have become more fully integrated into the community. Contrasted with their predecessors, the current generation of mental health clients have not experienced the great degree of institutionalisation and its related problems such as dependency and missed opportunities.

Maturity of care has also occurred through the budget expenditures and distribution as it provides a comprehensive continuum of care, exemplified in the following chart. For many years, over 80 percent of the funding has gone for community-based treatment, with less than 20 percent for inpatient psychiatric treatment. This is with the belief that the community is the most therapeutic environment, providing the greatest potential for self-fulfilment. In its present form this funding distribution represents a balanced and stable system of care that is to be maintained. If cost overruns are seen in inpatient accounts, further analyses are made to determine needed corrections, either through system change or programmatic enhancements. Presently as the system is at capacity, the challenge is in dealing with both extensive waiting lists and increasing inpatient costs.

1997 Funding Distribution
Between Community Based Services (84%) vs. Inpatient Services (16%)



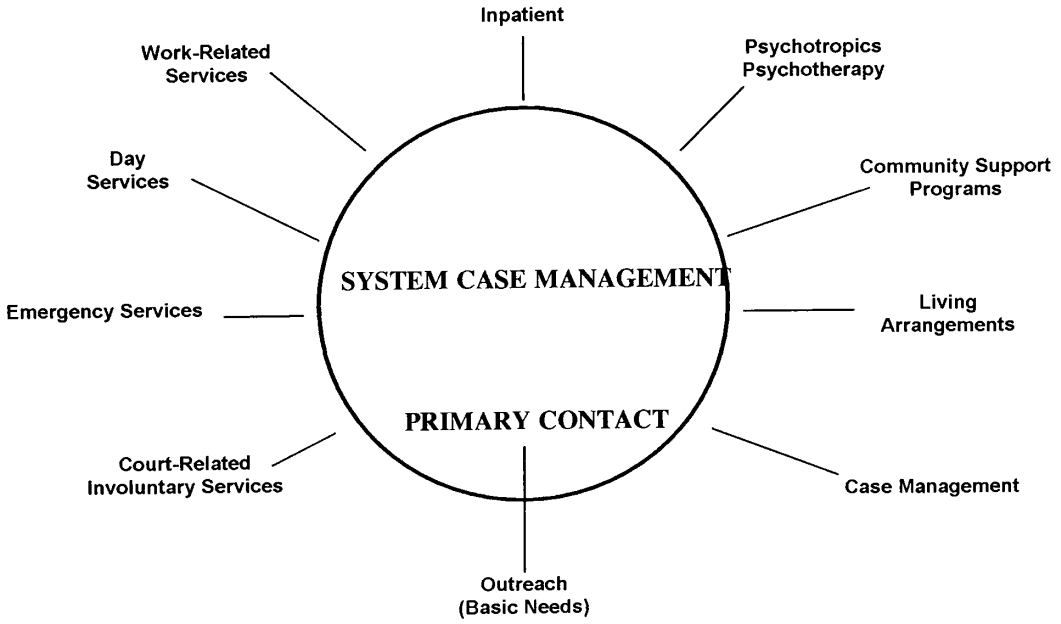
Expenditures	Amount	Percent
Community Support Programs	3,570,600	29.96
Living Arrangements	2,884,200	21.78
Case Management	1,481,400	11.19
In-patient		
-Acute/Invol: State Hosp.	855,800	6.46
-Acute/Vol: Comm. Hosp.	320,200	2.42
-Long-Term Inpatient	889,000	6.71
Crisis Intervention	1,073,700	8.11
Psychotherapy	774,800	5.85
Work-Related Services	484,400	3.66
Day Services	462,200	3.49
Outreach/Misc.	393,900	3.97
Med. Serv. Unit-Medications	53,900	0.41
TOTAL EXPENDITURES:	**$13,244,100**	**100%**

The maturity of the system is further manifested in the evolution and funding realignments that have occurred since its inception. The primary redistribution initially occurred by decreasing the funding for psychiatric inpatient services and providing more money for community-based services. Contract performance decisions have guided other funding realignments, as well as the inability of certain programs to meet the county's requirement of an integrated system of care. In all instances, these realignments have positively enhanced treatment programs. A representative example of this was the start up of the Crisis Home and Short-Term Care programs in 1988 by diverting funds from a high cost group home that had become more of a permanent than a transitional setting. The continuum of networks is apparent in its present form. Other aspects of system maturity will be discussed later.

The maturity of the system as it has evolved into its present form represents a mutual programmatic interdependency in order to perpetuate and maintain its balance. If clients cannot receive more intensive services on a proactive basis in the community because the system is at capacity, they will likely require hospitalisations. Further, if the highly structured supervised living arrangement system is not mobile, or if too many clients are hospitalised at any given time, they may have to wait longer in an inpatient psychiatric facility for community-based alternatives to be arranged. To date the system has been able to maintain this delicate balance despite remaining somewhat precarious.

2.6 AN INTEGRATED AND MULTI-TIERED SYSTEM OF CARE

COMMUNITY SUPPORT SYSTEM OVERVIEW
Level of Service Based on Level of Need



As previously indicated, the Dane County system initially began with multiple, single element service components and evolved into an integrated system of care. Loren Mosher and Lorenzo Burti described this model in their book Community Mental Health,

Principles, and Practice (1989). Since that time a level system has been used to define more clearly how services are matched with needs. This is very much in keeping with principles of managed care. The chart above illustrates the array of services, which exist on three levels:

Level I represents core level services. These programs are the most staff intensive, providing assertive outreach and continuous treatment approaches by dealing with clients at the highest risk for hospitalisation. The clinicians working at this level become keenly aware of "soft" signs of deterioration and therefore are more assertive in their treatment stabilisation efforts. This level requires all or most services to be consolidated within a single treatment team.

Level II represents some of the single service programs available either at the system's inception (1974) or developed later. This level of programming is available for clients who are less vulnerable to relapse and able to engage with multiple service providers to have their needs met. They may have a case manager through one program, receive medications through another, and participate in an altogether separate work program.

Level III programming provides for homeless or "unconnected" persons, where goals are to first meet basic needs (food, clothing, and shelter) and then ready clients for treatment. In some instances they may require involuntary treatment services. Since the core treatment programs were established (1986), the County has been concentrating more of its contracts with the basic needs network and has established monthly system co-ordination meetings to focus on getting more of these people into treatment. Staff working at this level are not referred to as "case managers," but are considered the primary contacts even though they perform similar functions such as procuring services and building relationships. A recent review of over 100 homeless people followed in this network over a two year period revealed that over 50 percent were connected with treatment programs during that time. We recognise that with this peripheral network the process of getting homeless people into treatment can take many years. Connecting timely treatment opportunities to individuals where they reside, on the streets and in the homeless shelters, has been crucial.

Clients are served at all levels and can rotate among these three tiers depending upon needs and their ability to be maintained within this system of care. As indicated above, all of the services are co-ordinated by case managers or staff who act as primary contact points, with centrally defined functions and system oversight. Treatment expectations vary based upon the degree of staff intensity available in each program, which is dependent upon the size of case loads and amount of time that can be devoted to each client. This levels system allows flexibility and change to occur in a more orderly fashion. While the goal of the system is to maintain high need clients within the most appropriate level of care, it is recognised that clients are highly mobile, and the system must respond to both positive and negative changes in their condition. For example, clients remain with Level I programming through a continuous treatment team, even though they have recently been evicted from their apartment and are currently residing in a Level III homeless shelter until another apartment can be obtained. In this system, the homeless shelter is under contract with the County, licensed by the State as a community-based residential treatment facility (group home), and acting as a staff intensive receiving centre. Staff at the shelter work with the CSP to reintegrate the client back into an independent apartment. The average length of stay at the shelter since its inception in 1988, has been three months.

Particular features of system case management designation are now identified by level of care:

- **Level I: Integrated, comprehensive core services:** In addition to the PACT program, there are five CSP teams provided through four programs at the Mental Health Centre of Dane County. Day services are modelled after the "Fountain House" program with psychosocial and vocational emphases. The psychiatric inpatient continuum includes Badger Prairie Health Care Centre (a county nursing home for long-term inpatient treatment), Mendota Mental Health Institute (a state-operated involuntary acute treatment centre), and three community hospitals with psychiatric wards (for voluntary acute treatment). System case management is provided for 650 people at this level.

- **Level II: Multiple single service programs:** Twenty-four hour response is available through the Emergency Services Unit. Psychotropic medications are provided by the Medical Services Unit. Four agencies offer short-term solution focused psychotherapy. All 40 programs provide case management services, but a Community Intervention Team performs this function exclusively at this level. While supported employment services are available through the CSPs and day service program, three other programs provide only work-related services. The internal supervised living arrangement system

consists of 201 supervised living arrangements with 102 group home slots in multiple sites, nine crisis home slots, seven short-term care slots, 35 adult family home settings, and some individualised living arrangements. Thirty-eight slots are provided in three congregate apartments and three boarding homes, all of which offer minimal staff support. While most of the programs at this level provide only a primary service, there are some exceptions. One example is the Mobile Outreach to Seniors Team (MOST), which offers case management, psychotherapy/psychotropics, and consultation services to the county's coalitions for the ageing. System case management is provided for 673 people at this level.

- **Level III: Services that integrate homeless and "unconnected" people:** The main function of this level is outreach. Programs here meet basic needs (food, clothing, and shelter) and attempt to connect people with mental health services through either a relationship approach or an involuntary process. Some of the programs/services here include homeless shelters, a transitional housing program, outreach workers, a medications clinic, and representative payees. Other related networks and agencies are involved, such as law enforcement, emergency response systems, and the Social Security Administration. Primary contact workers serve 214 persons.

2.7 MAJOR SERVICE AREAS IN THE SYSTEM

Blacksmith House—A Mental Health Centre CSP Neighborhood Program Office. Located at 923 Williamson Street.

2.7.1 Community Support Programs

Service Progression: **From PACT Demonstrated Research to System Integration**

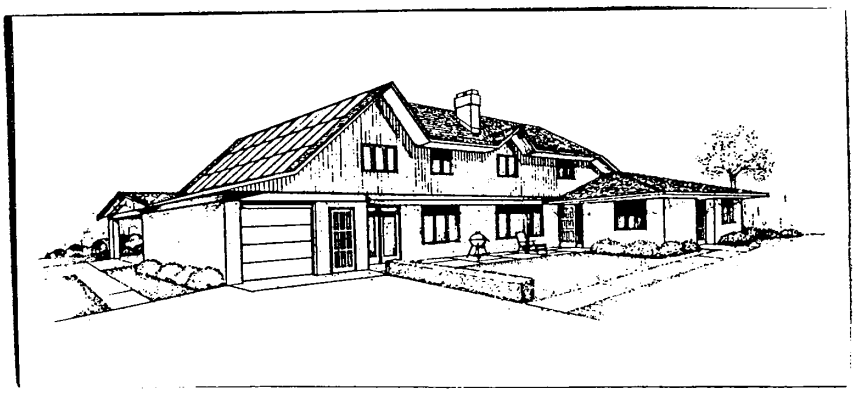
Although the entire system is viewed as a Community Support Program with many variations on this theme, for the purposes of this section, CSPs will be discussed in relation to the continuous, interdisciplinary treatment teams. Here the majority of their wraparound services are delivered in the community rather than in program offices.

Since the inception of the County system with the PACT approach arising as the most effective model for persons at highest risk of repeated inpatient treatment, the key variables have been timing, prioritisation, funding, and means of implementation. The State worked in conjunction with the Alliance for the Mentally Ill to realise PACT's implementation on a system-wide basis. The first steps were obtaining a CSP funding initiative in 1980 and obtaining Medical Assistance funding. This latter step set the stage for the promulgation of the 1989 HSS-63 Standards (State administrative rules), which were patterned after the PACT program, enabling more funds for the provision of these essential services. As a result, CSPs have become the predominant emphasis in a budgetary and service delivery sense. Almost one third of the clients (approximately 483 people) receive services through five programs representing six continuous treatment teams.

There are many features of the Community Support Program. An interdisciplinary team provides assertive and comprehensive services, mostly in the community (in vivo) to address the psychiatric and functional impairments of those most seriously mentally ill. The team treats mental illness symptoms with somatic and behavioural therapy and teaches clients awareness and self-management of those symptoms. They provide behavioural, supportive, and teaching strategies for dealing with functional deficits, such as limitations in social, vocational, and coping skills, and activities of daily living (ADLs) to enhance successful living in the community. The staff intensity of the CSP allows an increase in service delivery during periods of higher illness acuity. Staff-to-client ratios range from 1:8 to 1:13. Outcomes focus on low hospitalisation rates (25 percent or less), symptom

stabilisation, independent living, and paid employment. In addition, one CSP, Community Treatment Alternatives, which only accepts clients directly from the Dane County jail, has reduced jail recidivism by nearly 70 percent.

Community Support Programs have proven their worth, viability, and cost effectiveness. More CSP slots are needed. Many people continually enter the system and cannot access CSP services, while others are under-served in existing single service programs. Even though PACT has demonstrated the effectiveness of the assertive community treatment approach since 1978, 70 percent of public funding in the broader United States continues to fund inpatient treatment. The National Alliance for the Mentally Ill is currently working to institute the PACT model and its standards throughout the nation.



Northport Group Home—A Goodwill Industries Group Home.
Located at 1602 Northport Drive.

2.7.2 Living Arrangements

Service Progression: **From Substandard Apartments and Inexpensive Hotels to Supported-Living Arrangements to Integrated Apartments**

Dane county has progressed significantly from the days of discharging people from hospital settings directly to large, congregate hotels and other semi-supervised residences for indigent people, to now providing supportive living environments in the community. Changing times dictated the elimination of most of these outmoded facilities by 1985. The closing of each building was both a crisis and an opportunity to create more individualised and consumer friendly living environments. With the 1982 closing of a large residential care centre (166 beds), three additional group homes, an adult foster home program, and other less intensive supervised living arrangements were developed through special funding. The goal was to optimise community integration by individualising and supervising community living. Since then, other living arrangements providing internal staff support have been added.

Today approximately 88 percent of clients live in their own apartments with external staff support. Twelve percent live in a facility having internal staff supervision operated by or contracted with the county. The latter includes 35 persons at the Badger Prairie Health Care Centre (a county nursing home), 102 in group homes, and 48 in adult family homes and other individualised settings. Almost all of these 185 individuals will transition into their own apartments when prepared to live independently.

The evolution of client housing from an array of supervised transitional living to a well stratified system of higher to lower structure is shown in the following chart. In the beginning it took approximately 18 months for long-term institutionalised clients to transition out of high structure living arrangements into more independent living environments. Today those time frames have been greatly reduced because so many clients have become better acclimated to the community and require less supervision before taking the next step. At this time, there are no set time periods for clients to remain in staff supported settings. Currently group homes with the highest level of staff support are used

primarily by clients coming out of inpatient settings. The supervised living arrangements are mainly transitional and are used as a means toward the end goal of clients living independently with external supports.

Supervised Housing (1996 Data)

		Slots	Served
HIGH	**9 Group Homes**	**82**	**93**
	1 Receiving Centre	**20**	**139**
TO	**9 Crisis Homes**	**9**	**182**
	3 Short-Term Care Homes	**3**	**40**
LOW	**35 Adult Family Homes**	**35**	**48**
	3 Boarding Homes	**12**	**16**
STRUCTURE	**4 Congregate Apartments**	**40**	**45**
	TOTALS:	**201**	**563**

With the development of a continuum of treatment services, providers and clients have promoted quality, scattered-site housing instead of the large congregate buildings constructed by the public housing authorities. A "Values Group," whose members included clients living independently, originated in 1989 to discuss housing factors of importance to them and concluded that integrated, safe and affordable scattered site housing was their number one priority. Federal Housing and Urban Development (HUD) and county funding, combined with existing staff support (case management services), furthered the availability of supervised and quality independent apartment living arrangements since that time. The timing of our improvements coincided with the change in HUD emphasis from solely constructing living quarters to the inclusion of services to assist in more successful independent living. A private non-profit agency, Housing Initiatives, was incorporated to disseminate rent subsidies (whereby the client pays 30 percent of his/her income for rent), enabling 55 persons to reside in higher quality apartments integrated throughout the community. Other housing initiatives have been completed, and additional plans are in the offing.

A recent development is the incorporation into the system of a "Housing Resource Specialist" within the central entry point to track the availability of affordable housing that best meets client preferences. Both clients and providers are kept informed of the available housing stock. In this manner, community integration will further evolve, with the ultimate goal being home ownership.

2.7.3 Case Management

Service Progression: **From a Single Designation Within a Program to System-Wide Designation Across Multiple Programs**

Case management is the glue that holds the system together. In its purest form, case management functions encompass everything from assessment, treatment of symptoms, rehabilitation planning, interventions, and ongoing evaluation, to co-ordination and advocacy services for linkage and referrals. As staff-to-client ratios increase, the expectations become less pronounced. Levels I and II adhere to the purest form of case management. However, in Level III, the primary contact staff provide outreach services to meet basic needs and work over time to connect clients with treatment. Case managers do not necessarily provide all the services, but must see that all aspects of the treatment/rehabilitation programs are implemented within their program and across all other involved programs.

2.7.4 Emergency Services

Service Progression: **From Crisis Intervention to System-Wide Functions Emphasising Community-Based Treatment**

The nerve centre of the adult mental health system is the Emergency Services Unit (ESU), which started in 1968 in response to dictates from the courts. ESU's functions have expanded since then, especially in response to system demands. This energised unit works like a beehive, exemplifying the essence of creative problem solving at all levels. Staff at ESU interact with law enforcement personnel and an endless number of other community

resources. They work particularly hard to strengthen natural supports of the client, sometimes serve to fill gaps in the system, and although they can provide mobile services, generally respond to clients over the phone or as walk-ins. ESU is efficient and effective, with its focus always on the community as the primary treatment environment. Essential to maintaining its community emphasis during crisis triage dispositions is its operation as an independent unit apart from a hospital setting.

ESU was initially designated as the "gatekeeper" or entity for authorising inpatient hospital admissions. It was not until 1980 that its functions were broadened to include ongoing monitoring, facilitating, and implementing after care placements for all authorised admissions. This approach has more effectively minimised the use of hospitalisation.

Acting as the clearinghouse for inpatient admissions also affords ESU the opportunity to explore outpatient alternatives. All of the services developed over the years in lieu of inpatient treatment can now be fully utilised. According to ESU's 1996 outcome data, 67 percent of the 1,413 requests for hospitalisation were diverted to community treatment alternatives, many of which included follow-up of the client in the Crisis Unit or placement in a Crisis Home. True creativity emerges when ESU staff respond to a person experiencing stress and anxiety by capturing what the clients want and need to help them cope. Sometimes this means just having the client be with a friend or family member, or other natural supports. This approach frees up money for "capture the moment" type of plans such as providing a cup of coffee with a peer at a fast food restaurant.

Staff at ESU have a unique relationship with law enforcement, one that involves mutual training. A clear definition of roles exists in that law enforcement defines alleged dangerousness and ESU staff determine mental status, while both work toward an end disposition. This level of triage produces the most clinically and cost-effective disposition and conforms to the statutory requirements of least-restrictive alternatives. Policy at the Madison Police Department is that all persons potentially needing psychiatric hospitalisation, or who appear to be in a mental health crisis, be taken to the ESU for assessment and assistance in disposition.

ESU monitors civil commitments and settlement agreements to ensure that treatment requirements are met. As a part of this process, they also write a report to the court before the expiration of the commitment specifying their recommendations regarding extension or lapsing of the commitment. Crisis alerts can be established with ESU largely through the provider system when it is known a client is decompensating and may be needing a higher level response. Staff at ESU then work with the referring source to see that all voluntary, outpatient alternatives are applied.

ESU provides an all important 24-hour phone service for all eligible Dane County citizens needing a mental health response or experiencing a mental health crisis. ESU also provides an on-site staff linkage to the homeless shelters thereby facilitating entry into the mental health system.

Crisis Homes, which are certified adult family home sponsors, are under the direction of ESU and are frequently used in lieu of hospitalisation altogether or to shorten the length of inpatient stay. Of all Crisis Home placements, approximately 40 percent are in lieu of a hospital admission, 40 percent facilitate an earlier discharge from the hospital, and 20 percent represent a pre-crisis intervention or some sort of housing issue. Recent feedback from client participation in Crisis Homes shows 100 percent satisfaction with the home like atmosphere of Crisis Homes. Clients identified two features of this alternative that helped them: "time out from a stressful situation" and "being treated like a normal person." Present day clients who have not experienced years of institutionalisation do not see the psychiatric hospital as the only safe and secure setting for them when their symptoms become acute. Rather, they welcome the Crisis Home (living temporarily with a typical family unit), along with ESU backup, as an alternative to hospitalisation.

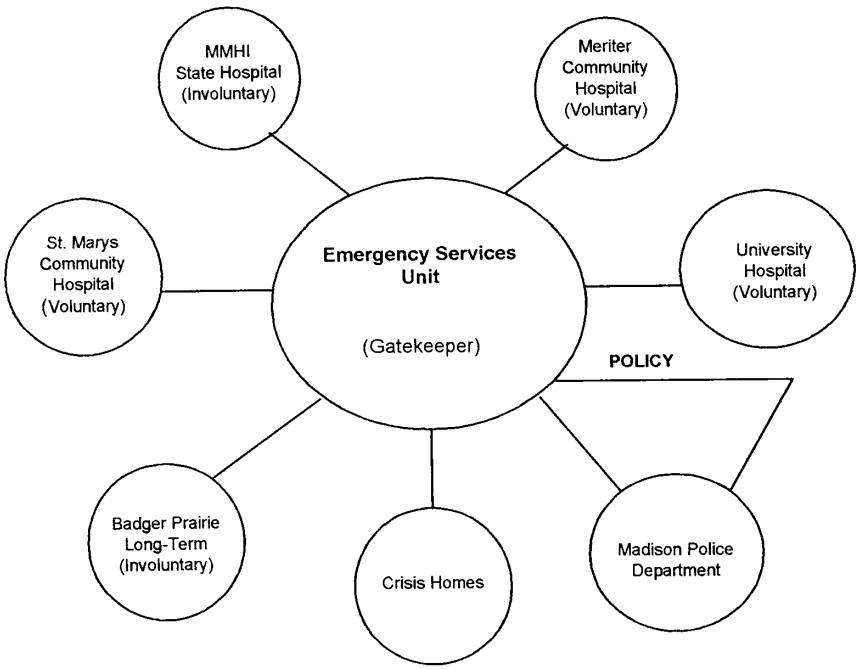
An ESU program used by the entire community is the "Survivors of Suicide" (SOS) support group for the significant others effected by the suicide or sudden death of a loved one. The support of peers and ESU staff helps to enhance coping after a tragic death and personal loss.

Finally, because the system is at capacity, many times the only way a person in urgent need of psychotropic medications can be served is through ESU. In addition to backing up Mental Health Centre programs after hours, this is another way Emergency Services backs up the entire system.

2.7.5 Inpatient Continuum

Service Progression: **From Uncontrolled Inpatient Usage to Authorised and Closely Monitored Inpatient Tracking**

Psychiatric Inpatient Continuum



1996 Data*

State Hospital - Acute, Involuntary
- Admissions 117
- Total Days 1,597
- Average Days/Person 14

Community Hospitals - Acute, Voluntary
- Admissions 69
- Total Days 323
- Average Days/Person 5

Badger Prairie (County) - Involuntary
- Average Length of Stay 1 year

Crisis Homes
- Admissions 182
- Total Days 542
- Average Days/Person 3

*This data excludes people authorised for voluntary community hospital inpatient treatment by ESU who have the ability to pay.

Many levels of symptom acuity are successfully and responsibly managed in the community. However, authorisation for inpatient hospital admission is granted when ESU staff have determined that the level of acuity requires a hospital setting and the presenting disorder can be appropriately treated therein. Two standards are followed: (1) inpatient treatment is used only when it is effective for the presenting problem and (2) all other outpatient treatments have been ruled out. Usually this means inpatient placement primarily for stabilisation of acute symptoms and for special medication titrating. An inpatient exceeding the average length of stay signals a special placement problem, which requires a review at all levels to ensure that either inpatient treatment is still warranted or all attempts to procure an alternative are being fully explored. Given all inpatient beds available in this community, it is estimated that 24 beds per 100,000 population are used exclusively by Dane County residents. This includes forensics patients, but not children.

Number of Psychiatric beds per 100,000 population:

General Hospitals (Acute beds):

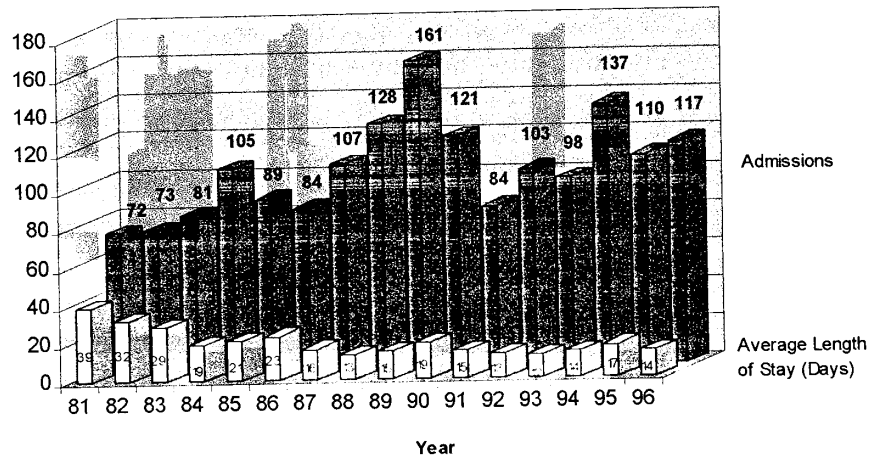
Hospital	Adult Beds	Ave Census	%County Residents	Total Dane Co.
Meriter	28	17	75%	13
University	20	20	60%	12
St Marys	22	13	75%	10
V.A. (Regional)	16	12	25%	3

Speciality Hospital Acute Beds Used by Dane County Residents:
Mendota Mental Health Institute (State Hosp.): 7

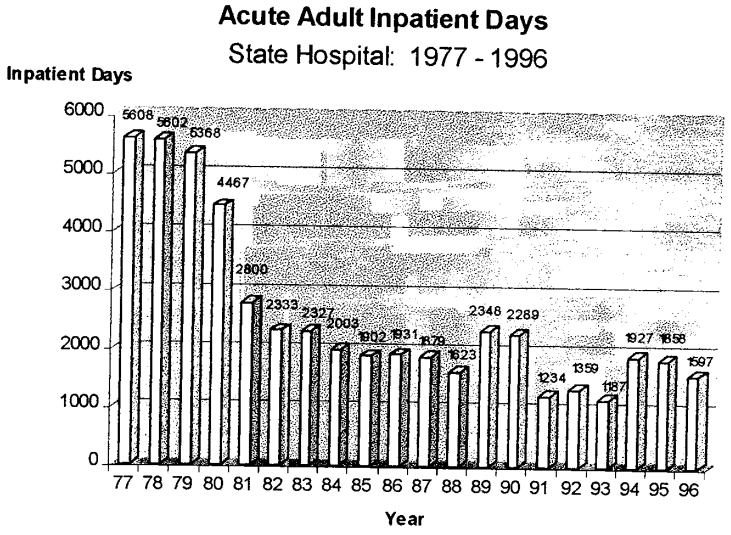
Long-term Hospital Beds Used by Dane County Residents:
Mendota (Forensics): 17
Badger Prairie Health Centre: 35

Total Adult Acute & Long-term Beds: 97

Acute Adult Inpatient Admissions
And Average Length of Stay
State Hospital: 1981-96



The stabilisation of inpatient utilisation is another measure of the system's maturity. Inpatient treatments range from short-term voluntary hospitalisation in community hospitals (average stay is five days), to longer-term involuntary hospitalisations at the state hospital (average stay of 15 days per episode over the last ten years) to long-term placements at the Badger Prairie Health Care Centre (average stay is one year). Today 35 clients reside at the locked ward Badger Prairie Health Care Centre (BPHCC) under a court-ordered, protective placement finding. Approximately one half of these inpatients will be discharged to the community during the course of a year, with the goal of all eventually returning to the community. Many participate in daytime programs in the community to keep them identified with the settings where they will soon be living. The court-ordered psychiatric unit at BPHCC first opened in August 1978. For its first six years (1978-84), the average length of stay at BPHCC was three years. Over the next six years (1984-89), it declined to two years. During the last six years (1990-96), the average length of stay has been only one year. This too demonstrates the natural progression occurring with the advent of more community support and better psychotropic drugs, particularly Clozaril.



The preceding charts depict involuntary inpatient utilisation at the state hospital, a key barometer in measuring the effectiveness of community-based treatment. By all measurements, forced inpatient utilisation has remained relatively constant for many years in terms of average lengths of stay and number of days, even though the number of admissions has increased. This was accomplished by designating responsibilities in existing programs and adding more alternative community programs, all of which provided for additional responsible and effective community-based alternatives. This stability has been achieved even though funding increases have not been commensurate with higher service demands.

Most involuntary inpatient admissions are for clients who are not connected to the treatment system for a variety of reasons. A five year review of admissions revealed over 70 percent of the admissions to the state hospital (Mendota Mental Health Institute) were first-time admissions for people who had few or no service connections with the contracted system. The implication here is that a more mature system of care allows for proactivity with service connected clients and hence minimise involuntary hospitalisations or provides brief voluntary hospitalisations in community hospitals. However, there will always be persons new to the system for whom an emergency response is required - a source of unpredictability.

2.7.6 Psychotherapy/Psychotropics

Service Progression: **From Long-Term Psychotherapy to Short-Term, Solution-Focused Therapy and Group Approaches**

In thinking about my experiences with psychotherapy, these are some thoughts that come to mind:

It's not just what you say;
It's how you say it,
It's not just how you feel;
It's what you may not be feeling,
It's not just that I don't understand what's wrong in my life;
It's developing insight and a course of corrective action,
It's not just a feeling of being isolated and alone;
It's knowing that somebody else cares,
It's not just experiencing active acute symptoms;
It's feeling some relief they are becoming more subdued.

Talk therapy and psychotropic medications, traditionally a part of the private practice community, have sometimes been difficult to obtain through the public sector. Recognising this need and realising the system was falling further behind in meeting psychotherapy and psychotropic needs, cost-effective alternatives were developed in order to serve more people.

Long-term psychotherapy has almost been eliminated within the Madison Model in favour of reaching more people through short-term, solution focused therapy. We have maximised the use of somatic treatments by establishing a separate Medical Services Unit (a nurse-psychiatrist medication clinic), by providing psychiatric consultation to primary health care clinics enabling indigent persons to receive psychotropics responsibly, and establishing a medication clinic in a homeless shelter. Multiple agencies are working co-operatively to provide group therapy - a key component in this effort. Therapy groups exist to deal with such varied issues as depression, parenting, divorce, stress, learning assertiveness, surviving sexual abuse, and support for living in public housing and release from jail. Some of the groups are provided directly in the neighbourhoods where participants reside.

A total of 547 people received these services in 1996, with a high degree of satisfaction reported. These are all examples of creative solutions recently developed.

Specialised, culturally competent psychotherapy programs are provided to persons in the Dane County jail system and to Southeast Asian persons (who primarily have a diagnosis of PTSD) in close proximity to their residences. Programming for both populations is successful because staff relate directly to where the person is at (contextual relevance) and because staff are culturally diverse and include indigenous workers. The jail mental health team also demonstrated excellent outcomes last year. Ninety-six percent of 400 people (382) assessed for emergency detention were successfully treated and maintained in the jail, rather than hospitalized. Sixty-three percent of 52 people (33), who had a serious psychiatric disorder and were not in treatment, were able to access community-based treatment upon release.

Yahara House—The Mental Health Centre's Day Service Program. Located at 802 East Gorham Street.

2.7.7 Day Services

Service Progression: **From a Traditional Day Treatment Psychotherapy Emphasis to a Supported Employment and Full-Time Independent Employment Focus**

Yahara House is the primary day program providing Level I services to over 200 people during the course of the year. While not offering the level of staff intensity and outreach assertiveness available in a CSP, Yahara House is proactive in many instances and also utilises peer supports. It is patterned after the "Fountain House" model and offers user-friendly and supportive services to all members who come to the House 365 days of the year. Yahara House was recently relocated to a renovated historic building near Lake Mendota whose personal charm and decor enhance its people supportive milieu. It offers members a variety of groups in which to participate. Transitional employment programs provide paid work for 40 percent, or 83 members. There is medication dispensing and "med groups" for many members. All members receive case management services. Meals are provided on-site in the Cafe Yahara located on the third floor. A retail store called Hidden Treasures provides work activity for members at another site, and benefits the community at large. The program also offers quality congregate living through its Stein and Perry Street apartment complexes (which are federal HUD-funded facilities). Staff and peer support are hallmarks of this program. Many different work groups and several consumer self-help groups (Recovery, Inc., Alcoholics Anonymous and Narcotic Anonymous) offer ongoing opportunities for self improvement. It's a delight to visit and enjoy a milieu that truly exudes empowerment.

2.7.8 Work Services

Service Progression: **From Sheltered Workshops in Segregated Sites to Supported Employment in Natural Work Sites Integrated into the Community**

Much of people's identity and self-fulfilment derive from satisfying work activity. It is little wonder that gainful work has become an important treatment outcome for mental health clients. Frequent discussions with consumers about work and the inherent disincentives in the system have led me to the following conclusion: "I value my life, my

worth, my dignity; can a system be established that will make the risk of work profitable on a personal and financial level?"

Some good things have happened which are promoting gainful employment within the mental health system. Sheltered workshops are "out" and competitive employment in natural community settings is "in." Make-work has been replaced with work based on interests and abilities. Mental health clients generally do not have to prove themselves based on earlier work performance in order to move on incrementally to more challenging work. Demeaning assembly-line tasks in segregated sites reinforced daydreaming, which magnified symptoms. These have been replaced with meaningful work in integrated community sites. Also now the employer - rather than a job coach - is often the primary supervisor. Work is being incorporated into existing treatment programs like the CSPs and Yahara House, thus eliminating the need for clients to have to go through yet another program to enter the work force. Symptom stabilization, the single most significant factor interfering with work for mental health clients, is better managed through newer psychotropics with fewer adverse side effects. When symptoms intensify, alternate plans are developed and implemented as needed. Medical leaves are common in the work force at large, and are also appropriate and responsible courses to follow for clients, given the cyclical nature of their mental illnesses. Employment occurs in many different natural work settings and mental health providers are hiring mental health clients for a variety of positions.

With this new generation of clients who have never experienced the devastating effects of years of institutionalisation, their socialisation has not been impeded by the dependency inducing hospital environment. With reasonable work incentives and better treatment, they are more ready to embrace the concept of work. Recent innovations reinforce their entry into employment, such as payment for training and higher education, which assist with both developing gainful employment and maintaining ongoing benefits (government checks and health insurance benefits). An attempt at more equitable mental health insurance on the same level with that of physical health insurance was passed by the federal government in the fall of 1996, providing yet another positive step in this direction.

The following statistics show the progress made in employing adult mental health clients: approximately 17 percent perform some level of significant competitive employment and a few clients have left the security of government checks to be on their own. This remains an important evaluation outcome measure. The chart below illustrates a net gain of 61 employees in paid work over the last six years, with an average hourly pay rate of $5.46, an average yearly income of $5,580 per person, and an annual average aggregate amount of $1,225,788 over all six years. It should be noted that in the PACT program, where the age range is 18-30 (clients with early onset of illness), the number of clients in paid employment exceeds 50 percent. With the maturity of the Madison Model, we anticipate an increase in numbers of clients in gainful employment. For more and more clients, full-time employment will become the goal.

Paid Work in Natural Community Work Settings

	1991	**1992**	**1995**	**1996**
Number Working	**196**	**200**	**220**	**257**
Average Hourly Wage	**$4.90**	**$5.13**	**$5.83**	**$5.97**
Average Hours Worked /Week	**20.00**	**20.80**	**18.41**	**19.60**
Average Earnings/Person	**$5,101**	**$5,550**	**$5,582**	**$6,090**
Annualised Aggregate Earnings	**$999,821**	**$1,110,017**	**$1,228,200**	**$1,565,116**

With continued exposure, clients achieve increased feelings of fulfilment and self-worth, providers get the satisfying realisation of a better treatment outcome, employers obtain

good employees, and the community gets productive and contributing members of society. We are committed to keeping this synergistic cycle evolving.

2.8 COURT-RELATED INVOLUNTARY PROCESS

While the great majority of services are provided on a voluntary and mutually agreed upon basis, the involuntary process provides a further element of stability within the community and for the system. Significantly, the involuntary system is one of the most confusing and least understood aspects of the adult mental health system. Corporation Counsel and court-related experts have been essential to a properly working system. Knowing who to call and under what circumstances are also critical elements. In every community of the state; attorneys, the courts, law enforcement personnel, and mental health professionals have developed their own community practices based on their interpretations of the state standards for involuntary commitment. The Madison community has attempted to uphold the highest criteria of state statutes. Through careful monitoring of court orders for commitment, a high level of credibility has thus been attained.

In terms of dangerousness, highly sensationalised media portrayals have perpetuated the myth that mentally ill persons are more likely to be dangerous to others. In reality they are much more likely to be dangerous to themselves - either through omission or overt self-destructive acts - or to be victims of crimes. In this community, we clearly understand that untreated or under-treated individuals with documented histories of dangerousness to others can once again pose threats to other people. Therefore, mental health professionals work closely with the law enforcement and judicial systems to assure that clients and society are better protected when treating persons with a history of dangerousness - meaning treating clients on an involuntary basis at times. Society's mandate for safety underscores the need for comprehensive community-based treatment with a capability for assertive outreach.

The involuntary processes in Dane County have been well defined and enforced. Corporation Counsel represents the County in civil commitments, incompetency determinations, and protective placement/services findings. The Adult Protective Services

Unit at the county level also works with Corporation Counsel, acts as the petitioner for guardianship and protective cases, and completes psychosocial assessments for privately initiated cases. It also monitors placements and services once court orders have been instituted. A Clinical Assessment Unit at the Mental Health Centre of Dane County completes the psychosocial reports and makes recommendations that frequently become incorporated into court-ordered services. The primary respondent is the Emergency Services Unit, whose staff work with law enforcement to comply with the Chapter 51 mandate for treatment in the least restrictive setting. Forensic findings are determined through the criminal justice system. In all court-related circumstances, clients have their own attorneys, and due process protections are in place. It is the County's duty to see that all civil court-ordered services are implemented and monitored for compliance with state statutes.

The breakdown of involuntary services for 1996 included a total of 373 persons under involuntary findings, or 24 percent of all persons (with a serious and persistent mental illness) receiving services which included the following: 119 people under civil commitments, 75 under settlement agreements, 158 in protective services/placements, and 21 conditionally released (forensic clients). In addition to the number of persons under involuntary findings in any given year, there are others who have as a condition of their probation or parole status the taking of psychotropic medications. For these people, non-compliance can lead to placement in the Dane County Public Protection and Safety Building (jail), where mental health services are provided in an internally secure environment.

3. THE ROLE OF USERS IN THE SYSTEM

The role of Users, referred to ad "consumers" in our system, parallels the development of the county public adult mental health system dating back to the early seventies. The earliest consumer support groups of which I am aware in Dane County were ex-patient group referencing their release from long-term inpatient stays. This was prior to the development of community-based services in Madison. Similar to the reason for the development of the

Alliance for the Mentally Ill (1977 - see section 3.1), their focus was to support each other and to combat professionals , for either blame or alleged abuses.

From the early "activists" was have evolved from adversarial to more working togethr relationships. This marked change in philosophy is evidenced by the difference in the name of the first consumer organisation which was called Network Against Psychiatric Assault (NAPA), to a current organisation entitled Psychiatric Reform Through Education, Visionary Action and Informed Leadership (PREVAIL). In 1976 the same statute that created the counties as being the fixed point of responsibilities for mental health services in the public sector also included a patient bill of rights that emphasised the least restrictive environment and treatment interventions, client grievance procedures, as well as due process for all involuntary psychiatric inpatient admissions. This legislation gave consumers more voice and formal avenues to pursue when dissatisfaction occurred. Over the last seventeen years, and coinciding with the development of a community-based treatment system, consumers and professional have been working more effectively together in advocacy, support and public education activities.

Today there are approximately seventeen consumer focused groups, organisations and programs that either operate within the county contracted adult system or are independent and run solely by consumers. Within the contracted system consumer involvement varies by the program. Yahara House, which has been explained more fully above, reflects the highest level of consume involvement with peer support groups and staff and consumers working together on all aspects of programming. Peer Connection if the only consumer operated private non-profit program that is under contract with the county. This program provides peer support via phone and has developed an excellent training manual for the consumer providing this service. A recently developed consumer and staff group call Vote For Mental Health has chosen a legislative and policy approach.

Consumers participate on boards and committees at all levels including hiring committees at the Mental Health Centre of Dane County. Consumers are encouraged to participate in many of the ongoing system co-ordination meetings and training events. Occasionally,

consumers will present their own training on issues and topics where they think professional are responding inadequately. One of the most recent consumer directed training sessions was in relation to helping professionals understand why persons with Borderline Personality Disorders self-abuse and how better to respond to those behaviours. Consumers, staff, and representatives from the Alliance for the Mentally Ill frequently work together on public education through all forms of media. We also work together to educate local neighbourhoods to combat 'NIMBY' (Not In My Back Yard) when siting group homes.

Consumers are hired within almost all of the programs but primarily work in staff supported housing programs. They also work as case aides, perform janitorial and house-keeping functions within mental health programs, and in some instances are case managers. Paid peer support is arranged through the Emergency Services Unit. The data on consumers in paid work outside the contracted system has been stated previously. Consumers are encouraged to, and do, file grievances, most of which are resolved within the programs in which they are originated. If satisfaction is not achieved at the program level it can be appealed to the county and the state. Consumers and staff mutually participate in the treatment planning, evaluation of the plan, and ongoing refinements in the plan. As evidence of the participation in this process consumers sign off on the agreed plan which is incorporated into the clinical record.

3.1 Role of the Alliance of the Mentally Ill

In September 1979 the Alliance for the Mentally Ill (AMI) of Dane County, Wisconsin, hosted the first national conference if families, who had a member(s) with a serious mental illness. The AMI was assisted by the University of Wisconsin-Extension in this historic gathering, which took place at the Wisconsin Centre and Alumni House on the campus of the University. Approximately 250 individuals from around the the United State particpated in the weekend activity.

The thrust of the conference was to ascertain whether persons - primarily families of persons with mental illness - were interested in forming a national alliance to work on behalf of persons with mental illnesses. Those in attendance emphatically agreed that the need for a "family" alliance was essential. Thus, during the weekend the structure and goals of the organisation were established, along with a steering committee to guide the development of what is now the National Alliance for the Mentally Ill (NAMI). The organisations exist to advocate, educate and provide support. At this time, NAMI has over 1000 affiliates and 150,000 members. The NAMI, among many projects, is currently actively involved in a five-year anti-stigma campaign to end discrimination against persons with the brain disorders termed the mental illnesses.

4. THE GOAL OF IMPROVING CLIENTS' QUALITY OF LIFE

Many sections of this chapter have focused on the positive aspects of individuals working together to improve clients' strengths and promote acceptance and community integration. The sections regarding living arrangements and work-related services are especially illustrative. The focus is not just on providing treatment - it's promoting a quality of life. This involves community awareness, acceptance, and raising clients' standard of living. It's also having fun and recreating. It's feeling inspired. It's everyone working together.

Following more than two decades of treatment services focused on community integration, mental health clients are feeling more empowered and better able to embrace the concept of recovery. The hope is that with ongoing community exposure and participation of mental health clients, their recovery process will be enhanced by the community's acceptance. No longer is it true that adult mental health clients isolated away in state hospitals with no hope for the future can be ignored by the surrounding community. The need to belong, a universal psychological need, can be fulfilled through the community's benevolence in providing employment, safe and affordable housing, and natural support systems; by acting as guardians; and by befriending persons with special needs. These all reduce stigma and isolation. We are working together as a community to make this happen.

Presently, there appears to be a better understanding of a holistic approach which is having a positive impact on personal development and the ongoing self-recovery process. The commitment continues to be toward working together in reinforcing and promoting the personal intrapsychic and interpersonal development of adult mental health clients. When professionals recognise and support the spiritual - motivational and inspirational - aspects of the client's personal development journey, the horizons of the adult mental health client expand. The path each person chooses to follow will be enhanced if we can mutually understand and promote the importance of natural supports, self-determination, and individualisation. Relationships will be established on the basis of mutual trust and respect. Even though the recognition and treatment of core symptoms are tasks of the mental health professionals, attention to clients' psychosocial functioning involves the entire community. Quality of life involves housing, employment, and recreation as important facilitators of the personal growth process; so too are the community's acceptance of employing clients and the enhancement of peer support services and networks. In addition, a strong appreciation of holistic self-discovery is essential to each person's self-fulfilment and ultimate life satisfaction. This process will continue to evolve and energise, leading to a new level of personal development and community integration.

5. CONCLUSION

I close with the critique provided by a mental health client following his reading of this preliminary report. Mr. Edward Erwin has been a long-time member of Yahara House. It is reproduced below with his permission.

> "Dignity of risk" is held up as a primary option for consumers. More importantly, it is a theme for management in an extremely responsible manner. The sense of values guiding decision making resulted in a system to which many owe much. I have, and continue to be, a part of this wonderful "mortal system." Its touch is something grown into it, and its caring too often taken for granted, even by myself.

I was struck by the sentences: "All of the services are co-ordinated by case managers with centrally defined responsibilities (functions). This allows for flexibility and change in an orderly fashion." I have felt the truth of this more than I have known it in these many, many years. My own and my peers' internal and external lives fit into the motion of our environment. It is our way of life. And we too often just live through rather than with these policies through levels of response to our own actions and those of others.

It is impossible to sever oneself from a bureaucracy to which one is medically bound. It is also impossible for me to not look upon it as part of my own plans. Having passed through the system so far, I have my own questions as much as the mental health system does. Where to from here? My only comment, based on seeing its evolution, is this: I have confidence.

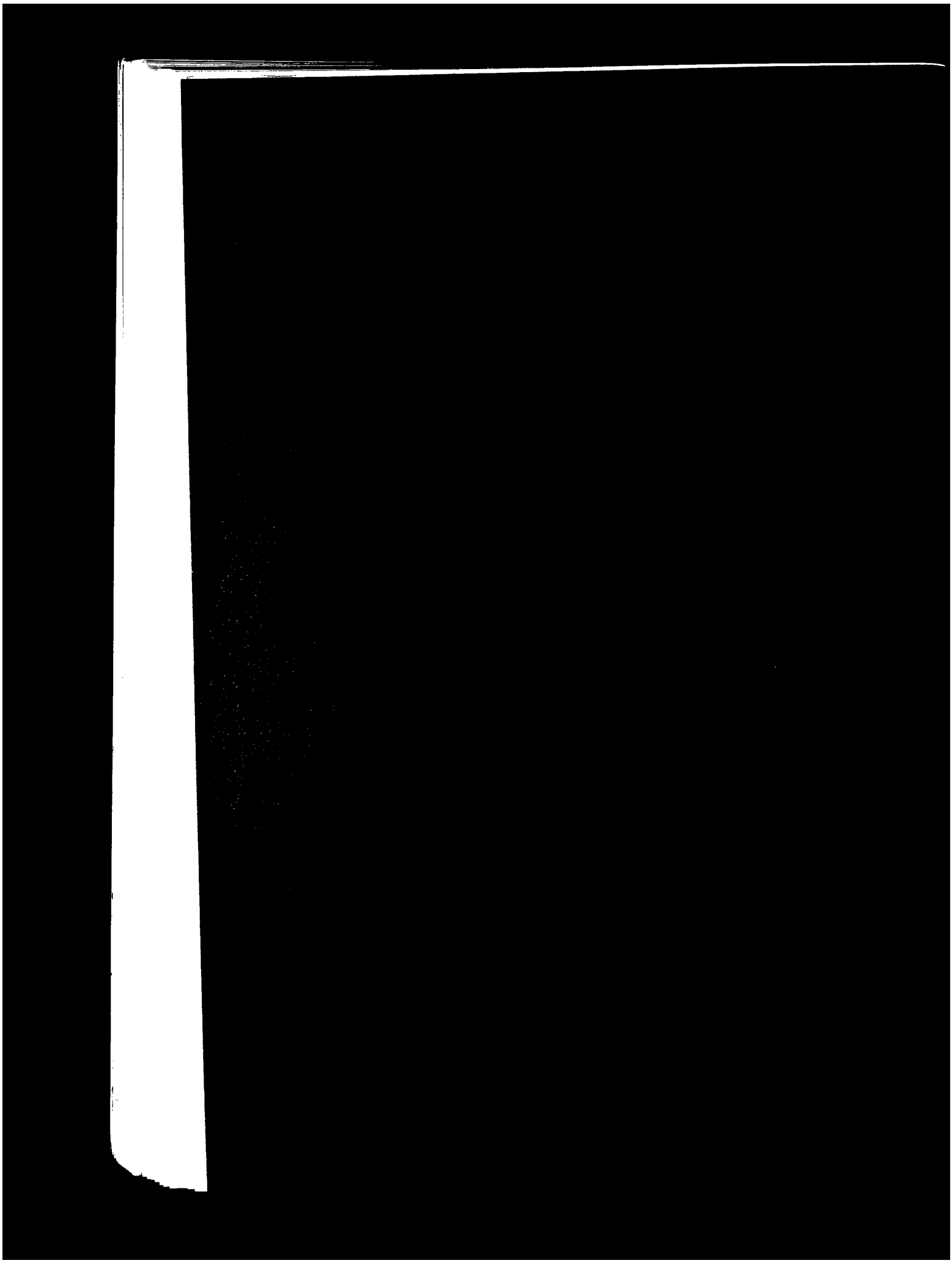
REFERENCES

Fried, Carla. "Best Places to Live in America: 1996." *Money*, Vol. 25(7), 1996, 66-73.

Mosher, Loren R. &Lorenzo Burti. (1989).*Community Mental Health: Principles and Practice*New York: W.W. Norton and Company.

Thompson, Kenneth S.,Ezra E. H. Griffith, and Philip J. Leaf."A Historical Review of the Madison Model of Community Care." *Hospital and Community Psychiatry*Vol. 41(6), 1990.

Torrey, E. Fuller., and Sidney M.Wolfe (1986).*Care of the Seriously Mentally Ill: A Rating of State Programs.* Washington, D.C.: Public Citizen Health Research Group.



CHAPTER 7

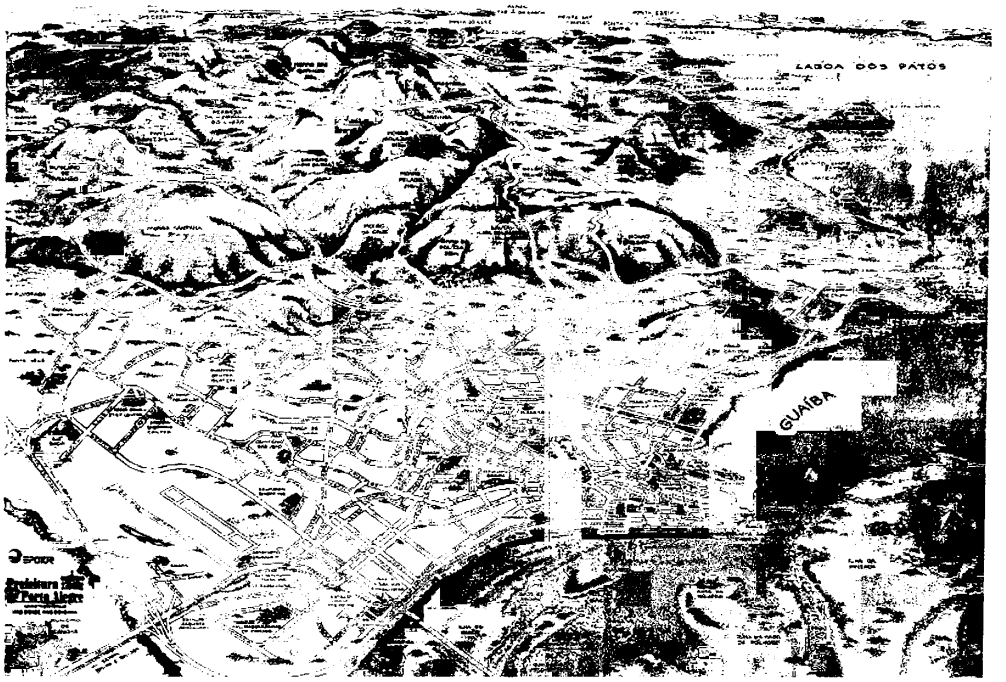
CITY OF PORTO ALEGRE, BRAZIL: The Brazilian concept of Quality of Life

Dinarte Ballester[1], Ana Tietzmann, Ariadne Geidel, Patrícia Zillmer, Maria Fischer, Miriam Dias, Ellis Busnello.

(1) Psychiatrist, Coordinator of the Social Psychiatry Program, Psychiatric Service of Hospital Materno-Infantil Presidente Vargas (HMIPV) and Fundação Faculdade Federal Ciências Médicas de Porto Alegre School of Medicine (FFFCMPA).

Rua Padre Chagas, 140/conj. 302
90570-080 Porto Alegre RSBrasil
dinarte@pro.via-rs.com.br
00 55 51 3284445 (phone)

CONTENTS



The Map
Mario Quintana

I look at the city map
As though I were examining
The anatomy of a body...
(as though it were my body)
I feel an infinite pain
For the streets of Porto Alegre
Where I will never go...
There are so many strange streetcorners
So many nuances on the walls
So many pretty girls
On the streets I have not strolled

(And there is a spellbound street
Of which I have not even dreamed...)
When I go, one of these days,
Like dust or a leaf swept along
By the wind in the small hours of the night
I will be a bit of the nothing
Invisible, delicious
Which makes your look
Seem more like a
Soft, mysterious, loving look.
The city of my strolls
(That I have been strolling for such a long time)
And maybe of my repose

1. THE CITY AND ITS HISTORY

1740 - Jerônimo de Ornelas, born on the Island of Madeira, Portugal, received the definitive title to the lands, and moved to the property with his whole family, relatives and employees. From then on, the modest settlement received groups of settlers selected and brought from the Azores by the Portuguese Government.

1772 - The settlement was officially founded and received the name of Our Lady Mother of God of Porto Alegre.

1773 - The central government of Brazil, as part of the Kingdom of Portugal, made Porto Alegre the capital city of Rio Grande do Sul. Urbanisation began and the main buildings were erected.

1822 - Emperor Dom Pedro I declared Brazil independent and in the same year raised Porto Alegre to the level of a City, by Imperial Letter.

1824 - German immigrants began to arrive and contributed greatly to the development of agriculture bringing in new industries.

1845 - After the Farroupilha Revolution the demands of the inhabitants and of the Porto Alegre City Council for improvements in the city were heard. Several civil works were built and community facilities were renewed, as the construction of the public marketplace.

1860 to 1886 - The city grew faster as industry developed. During this time period several improvements occurred, such as the inauguration of the Waterworks Company to supply drinking water to the whole population, inauguration of public transport, the telegraph station, the City Council Building, Public Library and São Pedro Psychiatric Hospital, as well as the Telephone Union .

1889 - The Republic was proclaimed in Brazil, and enthusiastically received by the inhabitants of Porto Alegre. The city of Porto Alegre entered the Twentieth Century with a large population and economically developed. Among the urban facilities were public transport, water and wastewater services, telephones, elementary and secondary schools and institutions of higher education, active trade, developing industries and a numerous, varied press.

2. PORTO ALEGRE TODAY

2.1 Demographic Structure

The conjunction of changes in demographic pattern and urbanisation at the end of this century has caused profound structural changes which will have a strong impact on the future of social and economic development in Brazil. The speedy urbanisation process that occurred between the years of 1940 and 1980 led to a significant reduction in the rural population and in towns with less than 20,000 inhabitants. The population in these areas dropped from 85% to 46%, while the remainder drifted to urban areas. Large cities with more than half a million population accounted for 32% of the population.

Beginning in the 1980s, this process underwent a reversal, involving a significant reduction in urban population growth rate and deceleration of the population concentration in the large cities. Thus, the core cities of metropolitan areas such as Porto Alegre presented a reduction in their annual growth rates during the 1970s and 1980s, growing less than their metropolitan regions. In Porto Alegre the annual growth rate which had been 2.4% between 1970 and 1980 became 1.1% between 1980 and 1991.

The city of Porto Alegre has a total area of 471 km^2, consisting of a continental part of 428 km^2 and the Islands, 43 km^2 . The Porto Alegre population, after the county boundaries with Viamão changed in 1992, is 1.25 million inhabitants, with a demographic density of 2.6 inhabitants/km^2. The age structure of the population is that 27% of the population are below the age of 15, two-thirds are between 15 and 64, and the remaining 6.6% above 65 years old. The fact that the school age population is growing at an increasingly smaller rate, which will extend to the end of the century, allows a slower expansion of the education system. The investment in education should be made not by increasing the physical facilities but mainly by raising the quality of teaching in Brazilian schools. The Brazilian education system is generally considered very weak, and requires a leap forward in quality to overcome the deficiencies found in elementary and secondary schools. The rising number of aged in the population forecast by all demographic studies could worsen the problem of unassisted senior citizens that already occurs in Brazil. The aged will find it

harder to survive since they will belong to smaller and smaller families, due to the sharp decrease in fertility which has occurred in Brazil. This sector of the population has trouble finding shelter and help from children and close relatives, and represents a difficult social problem.

2.2 Economic aspects

i. The Participative budget

This budget was adopted to prepare the Plan of Investments to be made in the city with the participation of the population. It is a public form of civil power, independent of the government. It allows citizens to participate in municipal government and make decisions about the budget as a whole. This means greater democracy, since the population participates in local government. The city is divided into 16 regions, in each of which meetings are held to discuss priorities and elect councillors. Meetings since 1994 have addressed five main themes: transportation; economic development and taxation; city organisation and urban development; health and welfare; and education, culture and leisure. Thus, it is easy to participate: all it takes is that citizens attend the meetings which are always announced by the neighbourhood associations and in the press. Meetings are also held in the communities to choose local priorities: sanitation, paving, housing, health, education, and so on.

At the intermediate meetings more delegates may be elected, considering the people present at the meeting with the highest quorum, and using the same criteria as for the election of delegates during the first round. Then the Forum of Delegates is completed in each of the regions and themes. Resources to be invested in the city are apportioned according to the following criteria, since the regions are unequal: lack of a service or urban infrastructure in the region, and size of the total population. These criteria receive scores and weights, which make it possible to set up a grid with all regions and the investments to be made in them.

ii. Economic sectors

Porto Alegre county has three main economic sectors: agriculture and animal husbandry, industry, services and trade. In 1992, the municipal per capita income was US$5,307.

Approximately 30% of the territory of the capital is described as rural, over half of it with farming potential. The main agricultural products in the county are peaches, oranges, husk rice, manioc and tomatoes. Besides agriculture there are also animal husbandry activities with poultry, pigs, cows and sheep, as well as dairy products. However, only 0.5% of the municipal work force is employed in the agricultural sector.

The manufacturing industry has a small share in jobs in Porto Alegre, with 11.0% of the overall work force (PMPA,1996). Manufacturing can be divided into two approximately equal segments: modern industry (such as metallurgy, mechanics, electronics, rubber, chemistry, plastics and pharmaceuticals) and traditional industry (such as furniture and wood products, arts and crafts, textiles, clothing, footwear, foodstuffs, glass, ceramics, building materials and printing).

Finally, services account for 16% of the total jobs, and services account for the remainder of the workforce.

iii. Jobs and income

The picture of macroeconomic instability in the Brazilian economy since the beginning of the 1980s, with a drop in the rate of investments, a fall in manufacturing in a context of economic expansion has had a negative impact on the world of labour, worsening the already dramatic social inequalities in Brazil. This has led to the establishment of employment promotion policies and compensatory social policies.

Income distribution is concentrated in the same way as in the rest of the country, although Porto Alegre's Gini index, 0.57 in 1991, is lower as compared with other Brazilian cities.

The Gini index measures income inequality, and its limit values are 0 and 1. In other words, maximum inequality would attain index 1, whereas at 0 all inhabitants would have the same income.

2.3 Profile of the Economically Active Population

The Active Age Population (AAP) consisted of just over 1 million persons in 1993, corresponding to 83% of the people living in the county that year. Females predominate in this population, representing 54% of this group. Most of those in the AAP (84,6%) were Caucasian. The heads of households constituted 36% of the AAP, while spouses represented 24.2% and children 31% of the total. The Economically Active Population (EAP) of Porto Alegre in 1993 was 601,000 persons, of whom 89% had an occupation, and the other 11% were unemployed or looking for work.

Individuals in the 18-24 year age group and those 25-39 had the most significant rates of participation in employment (72% and 81%, respectively), while among persons 40 years old and over, only half (50,6%) were economically active. Caucasian individuals had a slightly lower rate of participation in the labour market than non-Caucasians (56% versus 59%).

Distribution of income: Only about 12.1% of the population earned below the recommended minimum wage, and 19% earned between 5 and 10 times the minimum wage, with a further 18% earning more than 10 times the minimum wage. However, even greater inequalities are found in other Brazilian cities.

Absolute Poverty Line in Porto Alegre: The 1990s have been marked by renewed interest on the part of international agencies such as UNO and the World Bank in the reduction of absolute poverty. In several countries, of which Brazil is a clear example, the benefits of economic growth have not been extended to the population as a whole. Thus, contrasts in levels of income and living conditions between the poor and non-poor persist and continue to rise, especially in the urban areas where the phenomenon is more visible. Approximately

one third of a million individuals, or 92,000 families, were below the absolute poverty line in Porto Alegre in 1993. The profile of the poor population indicates that poor families are larger, on average (3.9 individuals as compared with 3.1 in other families), with predominance of younger people (47.3% of the poor individuals are aged up to 17, while 29.7% of the non-poor are in this age range). Children and non-Caucasians are also over-represented, and the level of formal schooling is low among poor people.

2.4 Housing, basic sanitation and transport

According to the 1991 Census, in Porto Alegre there are 325,461 domiciles with 4 or more rooms, representing 85,7% of the total number of homes. This indicates a reasonable degree of comfort in the home for most of the population, taking into account that there are, on average, 3.29 residents per domicile and 5.80 rooms per home. In 1996, 99% of the Porto Alegre population had drinking water supplied inside their homes, and 78% had sanitary installations connected to the general sewage network. Garbage collection in Porto Alegre covers all homes, after Project "Garbage Collection in Areas Difficult to Approach" was implemented in 1990. Selective domestic garbage collection, implemented in the County in 1990, covers 97% of the city neighbourhoods, and also provides income for over 250 people who survive directly from the sale of materials obtained in the selective garbage collection (PMPA,1996). Seventy eight percent of the road system of Porto Alegre is paved. The housing situation of the low income population is a historical problem in Brazil. The population living in sub-normal domiciles, also called "favelas", has grown from 3,1% to 4,2% of the Brazilian counties during the eighties. In the Porto Alegre Metropolitan Region, in 1991, there were 105 favelas, with 31.781 homes. More recent estimates performed by the Municipal Department of Housing indicate that there are 289 favelas, with 20,4% of the city's population, in 67.470 domiciles.

2.5 Education

The situation regarding education in Brazil, despite considerable recent improvements, is still considered very poor as compared, for instance, with that of the other seven richest

countries of Latin-America, in which the average schooling of the population is 6.9 years, whereas in Brazil it is around 4 years. This factor has great weight since it conditions the quality of the work force which, in turn, is associated with the level of formal education and influences the income from work. The literacy rate in the urban area was 95%, and 80% in the rural area. There are four Municipal special schools for children with special educational needs, as well as other private schools.

2.6 Culture, leisure and sports

The County of Porto Alegre has 10 universities or colleges, 38 buildings which have been registered as National Heritage, 26 libraries, 24 museums, 12 theatres, 39 art galleries, and 22 auditoriums.

3 HEALTH

3.1 Life expectancy and low birth weight babies

Life Expectancy at Birth during the three-year period from 1979 to 1981 was 64 for males and 74 for females, a figure lower than that for the most recent estimate - 76.6yrs. An assessment of the percentages of low birth weight (less than 2500g) showed an increase in the last few years, from 8.9 in 1992 to 9.4 in 1995. This figure in intermediate between that for developed countries such as Sweden (4%), and developing countries like India (30%). In Porto Alegre, low weight related to prematurity constituted 52% of the cases and intrauterine malnutrition 48%.

3.2 Health Policies in Brazil & Porto Alegre

Health in Brazil is organised under the form of the Unified Health System (*Sistema Único de Saúde, SUS*), according to which health is the right of the citizen and the duty of the State, independent of any contribution paid to Social Security.

The principles of SUS are universal health care coverage; full, broad health care; equality, that is all have the right to health, taking into account social inequalities, social justice and income redistribution; decentralisation of health actions, so that the Counties alone are in charge of system management; and community participation in the formulation of strategies, inspection and social control of health actions, through the Health Conferences and Health Councils, at the national, state and municipal levels. They are constituted by representatives of managers, service providers, health care workers and the population of health service users. The participation of the community (users) should have parity with the other segments.

The SUS is a public system funded by the government (federal, state and municipal), with resources from the social contributions of employers and employees (based on the payroll), invoicing and profit of companies, revenue from prognostic competitions (lotteries), public budgets, rates and taxes.

Care for the population is provided via government services and private services which have an agreement or a contract, the latter to complement the government service network. Besides the SUS service network, there is a broad range of private health services and different levels of complexity, which the population can access via private health plans or direct payment.

In Brazil, in the last decades, the public health services have been scrapped and great privileges were bestowed on private health services. The care supplied by these services is known to be rather inaccessible and expensive. More sophisticated diagnostic and therapeutic resources are used to excess in some cases, although they are unattainable for most of the population at times when they would be essential. Moreover, users are often obliged to pay for procedures "on the side", even though they are funding the public health services by paying direct and indirect taxes .

The low capacity of public out-patient care units to solve problems, both in Porto Alegre and in the Metropolitan Region generates demands which wind up in the hospital

emergency services, and affect the ability of these services to care for real emergencies. According to assessments by the Emergency Service of the Hospital de Clínicas de Porto Alegre, 75% of the cases seen would be simple visits to the doctor.

The County of Porto Alegre took over the running of the health system alone in August 1996, by transferring financial, political and administrative management as well as personnel, equipment (physical structures), actions and services from the federal and state government levels to the counties.

The population has difficulty in obtaining hospital beds, since approximately 48% of the hospital admissions are people from the interior of the state. For some specific diseases such as heart, cancer and AIDS there is a lack of beds. The City Administration took over 51 state and federal Health Units which were in a bad condition, and over 1500 employees, besides the areas that were insufficient. This was in addition to 15 other units, that the City Administration was already maintaining. The Administration has been working to change this profile, giving 14% of its budget to Health. Of this total, 48% are consumed by the Hospital de Pronto Socorro (the city emergency hospital) to which people come from all over the state.

A computerised central station is being implemented to make appointments for visits and specialised exams to ensure that everyone has equal right of access to specialised care. The purpose of the central station is to organise the service and identify areas with a higher demand and lack of specialists; in this system the Health Unit makes the appointments. In 1996, the Municipal Department of Health set up 24 teams of the Family Health Project (*PSF-Projeto de Saúde da Família*) in deprived areas without health care. These sites were defined by the community in the regional fora of Participative Budget delegates, Local Health Councils and approved by the Municipal Health Council. The present situation is a major challenge to be faced in order to organise and manage services for the best care of the population.

3.3 Mental health policy in Porto Alegre

The first milestone of public mental health care occurred when psychiatric hospitals were created at the end of last century. Hospital Psiquiátrico São Pedro, founded in 1884, was the first specialised service for the care of mental patients. Over the years conditions deteriorated because of overcrowding, with up to 5,000 patients in the sixties, at the same time as expenditures were concentrated on mental health.

Beginning in the nineteen seventies, the state expanded mental health services. In contrast to the rest of Brazil, the state of Rio Grande do Sul established mental health out-patient clinics at the Sanitary Units, and installed the Centre for Agricultural Rehabilitation at Colonia Itapuã. A specialised out-patient clinic was also set up, the Central de Psiquiatria, unconnected with the general health services.

The private services network under agreements with the public system, expanded in the state interior and the capital, and alternative services were set up, including day hospital, sheltered housing, and therapeutic communities. At the same time, the general living conditions among the population at large became worse due to the economic policy of the military dictatorship. At the end of the seventies, the State mental health guidelines aimed at dehospitalisation, sectorisation, preventive work, and making use of local resources and general health services.

Beginning in the eighties, priorities and programmes were defined based on the World Health Organisation proposal for Primary Health Care. These health actions had a limited effect due to insufficient investment of resources and discontinuity caused by changes in public administration. The changes in Brazil's health policy, especially after the 1988 Constitution, influenced the lines of mental health care. Similarly, the National Conferences on Mental Health, in 1987 and 1991, caused major changes in legislation.

In the state of Rio Grande do Sul, the Law of Psychiatric Reform was passed in 1992, legitimising the need to reorganise mental health care. The Law determines that beds in

psychiatric hospitals will be progressively replaced by a complete mental health care system. It determines rules to protect people suffering from psychiatric problems, especially from compulsory psychiatric hospitalisation. These changes are to come about by means of a single management for the different services and their organisations in districts, respecting universal need for health, and the principles of equality and user participation.

3.4 Principles and Guidelines for the Mental Health Service

The full mental health care services should:

- be constituted by interdisciplinary teams
- allow the subjects to maintain or construct their own social and cultural bonds
- receive all those who seek the services, without any distinction which might lead to exclusion and segregation
- avoid social isolation and complete permanent invalidity caused by prolonged hospitalisation, especially in psychiatric hospitals
- permanently question the health workers as to their daily practice and relationships established with the public institution, the team, the users and the community
- organise the services in order to make them available for care and/or listening
- identify the form of community organisation, cultural and social patterns, potential and manifest forms of expression
- question the belief that links mental disease directly to disability
- establish channels of communication for users to plan and assess the functioning of the services
- treat persons as to their unique aspects, acknowledging each one's critical capacity and choice of mode of treatment appropriate to their needs, as well as their evaluation of it
- acknowledge that each person knows his symptoms, disease, development capacity, life and plans
- the therapeutic plan should take into account the new meaning and/or construction of life projects of each individual, shared socially (family, friends, neighbours, community, institutions)

- respect the mental patients as citizens, acknowledging the truth in their discourse
- acknowledge mental patients as citizens beyond what the diagnosis defines as their disease
- avoid the reductionism of the biological paradigm incorporating the contributions of the different fields of knowledge, such as anthropology, psychoanalysis, sociology
- develop projects to provide full attention to mental health among the population currently living on the streets right where they are, respecting the values and behavioural patterns constituted based on this reality

This whole process of change is permeated by the principle of building up citizenship which assumes that there are self-organisation processes favouring expression, participation and the constitution of the identity of an individual in his relationship with the world and his fellow men.

3.5 The Municipal Mental Health Plan

The Municipal Mental Health Plan organises the public services respecting the specificities of each Health District (approx. 100,000 people). The health teams at each Health Unit must be able to respond to the mental health demands integrated with the other health actions. Mental health teams should be part of more complex general services and Centres of Integrated Mental Health Care (CAIS Mental Centres) to attend to more complex levels of care. The Therapeutic and Income Generation Workshops may be linked to the CAIS Mental Centres and Sheltered Housing distributed throughout the districts where there is a specific demand for this type of service. Moreover, services are to be established for emergencies as well as beds for admission to General Hospitals.

3.6 Health Teams in General Services

The health care provided by interdisciplinary teams is permeated by mental health actions since it may foster the expression of feelings on the part of a person who comes to the service for any procedure and take comprehensive care of the individual. Therefore, every health worker can be a mental health agent. In order to do so it is necessary to train,

supervise and provide continued education for these professionals.

3.7 The Mental Health Team

This team must respond to the demands referred to them by the other health services in the district, supervise and advise the work performed by the other units, and interact with CAIS Mental. This is the team which must resist the trend to centralisation of health actions at hospitals and work with the institutions and the organised community of the area it covers, on social processes that generate a risk of psychiatric disease.

The team should consist of a psychologist, psychiatrist, psychiatric nurse, and social worker. It only exists in places where the need is greater due to higher demographic density, demand and/or lack of resources to provide welfare.

3.8 Centres of Integrated Mental Health Care (CAIS Mental Centres)

In the original proposal, this should be characterised as a specialised service with immediate availability and beds for brief hospital stays and observation, functioning 24 hours a day as a specialised place of reference for each district. The team should consist of psychologists, social workers, psychiatrists, therapeutic "friend", nursing aides, nurse, occupational therapist, psychological health teacher, physical education teacher and audiologist.

Currently, there are only two CAIS Mental Centres providing out-patient care, day care centre and therapeutic workshops. The day care centre receives patients who have been discharged from psychiatric hospitals or are in crisis and remain under treatment during the daytime. The therapeutic workshops are co-ordinated by occupational therapists.

3.9 Sheltered Workshops

The purpose of the workshops is to develop activities of socialisation, professional

education, leisure and art, for patients referred by health teams and open to the community at large. They are to integrate the mental health service user in the community to which s/he belongs. In order to function they must integrate with the Department of Health, Education, Culture, Foundation of Social and Community Education and other agencies of organised civil society. The CAIS Mental Centre team is to co-ordinate the work developed together with professionals from specific fields such as: figurative arts, ceramics, music, dancing, handicrafts. The Sheltered Workshop should foster the establishment of work co-operatives depending on how the activities in these workshops continue to develop.

3.10 Sheltered Housing

The Sheltered Housing Project offers a concrete opportunity to put aside the asylum model for patients who have become institutionalised, without any real prospects of entering or re-entering society. Section 5.3 of this Report presents a more detailed description of the Project.

3.11 Mental Health Emergencies

The goal to be achieved is integration with the general emergency services of the Emergency Hospitals and/or General Hospitals in the districts, with a team constituted by nurses, general practitioner, psychiatrists, neurologists, psychologist, social worker, and nursing aides. Currently emergency care for the whole city is provided at the "Psychiatric Central" only during the daytime and is not sufficient to satisfy demand. Some cases are seen in the admissions services of psychiatric hospitals

3.12 The role of the General Hospital Mental Health Unit

The goal of the Mental Health Units of General Hospitals should be short hospital stays, receiving patients referred by public and/or extra-hospital university services and developing multi-professional therapeutic activities in order to achieve remission of the symptoms and/or signs which caused hospitalisation. It should be pointed out that for this

purpose it is necessary to have a daily programme of therapeutic activities, besides medication and family group involvement in this programme.

The team should provide care for the other units of the hospital when psychiatric events occur and for psychoprophylactic activities. The multi-professional team should promote systematic contacts with the health service network in its district, creating a system of reference and counter-reference. The number of psychiatric beds available in general hospital should obey the ruling of the Ministry of Health in which 10% of the bed capacity is to be provided for psychiatric care, up to a maximum of 30 beds per hospital.

The understanding is that the institutionalising functions of the Mental Hospitals and the stigma associated with them prevent them from establishing satisfactory conditions for therapeutic change. Human resources currently located at these places should be transferred to the general care network. Since Mental Health Units in General Hospitals and other community services can more effectively solve and take care of existing demands, Mental Hospitals will be gradually decommissioned.

4 PSYCHIATRIC MORBIDITY INDICATORS IN PORTO ALEGRE

According to data from the Psychiatric Morbidity Study on the Urban Population of Porto Alegre, performed in 1990/91 by Professor Busnello and his colleagues, the estimated prevalence of psychiatric morbidity in the Porto Alegre population is 49%. The three most frequent diagnoses are: disorders due to the use of psychoactive substances (24.6%); anxiety disorders (23%) and affective disorders (10.7%). When the diagnosis of tobacco dependence whose prevalence was estimated as 20.1% is excluded, there is still a high estimated prevalence of mental disease of 42.7%.

Alcohol use disorders, including abuse and dependence, have an estimated prevalence of 8.8%, and in men the risk is considerably higher than in women (Relative Risk: 7.13). For the other psychoactive substances a population estimate of 2.5% was found. In the Anxiety

Disorders group, the diagnosis of Simple Phobia has an estimated prevalence of 12.8%, with a higher risk among women (RR:2.53). The other anxiety disorders have the following population estimates: Generalised Anxiety (6.7%), Agoraphobia (2.8%), Obsessive-Compulsive Disorder (2.6%), Panic Disorder (1.1%), Others (1.1%). Among the Affective Disorders, the third most frequently observed group of diagnoses, estimates were as follows: Major Depression (5.7%), Dysthymic Disorder (4.6%), Bipolar Disorder (0.6%), Cyclothymic Disorder (0.6%). The fourth most frequent disorder referred to mental deficiency, with a population estimate of 4.6%, high as compared to data from literature (3%), which could be attributed to socio-economic conditions. Schizophrenia has an estimated prevalence of 0.9%.

Table 6.1 describes the groups of diagnoses and the percentage prevalence coefficients in the sample and estimated prevalence in the general population:

Disease*	**N**	**Prevalence (in the sample) %**	**Prevalence** (estimated) %**
General total (including smoking)	(163)	58.4	49.0
Disorder due to use of psychoactive substances			
Total	(81)	29.0	24.6
Tobacco dependence	(65)	23.3	20.1
Alcohol use disorder	(24)	8.6	8.8
Disorder due to use of other substances	(10)	3.6	2.5
Anxiety disorders			
Total	(80)	28.7	23.0
Simple phobia	(46)	16.5	12.8
Generalised anxiety	(31)	11.1	6.7
Agoraphobia	(8)	2.9	2.8
Obsessive-compulsive disorder	(7)	2.5	1.6

Social phobia	(5)	1.8	0.9
Other anxiety disorders	(3)	1.1	1.5
Panic disorders	(2)	0.7	1.1
Affective disorders			
Total	(40)	14.3	10.7
Major depression	(21)	7.5	5.7
Dysthymic disorder	(18)	6.5	4.6
Bipolar disorder	(2)	0.7	0.6
Cyclothymic disorder	(1)	0.4	0.6
Mental deficiency	(12)	4.3	4.6
Psychological factors affecting physical status	(12)	4.3	3.5
Somatoform disorders	(18)	0.5	3.2
Adjustment disorders	(5)	1.8	1.4
Organic Brain Diseases (Dementia)	(6)	2.2	1.2
Schizophrenia	(4)	1.4	0.9
Other psychotic disorders	(1)	0.4	0.1

* Diagnostic criteria according to DSM-III
** Population estimate adjusted by distribution of gender QMPA
Obs.: No atypical bipolar disorder, paranoia, food disorders, factitious disorders and impulse control cases were found. Psychosexual disorders were not researched.

The estimate for the potential demand of mental disorders in Porto Alegre is higher for alcohol abuse or dependence and anxiety disorders and depression, as observed in table 6.2.

This study was part of the Multicentred Study on Neurological and Psychiatric Morbidity in Brazilian Urban Areas which constituted the first experience in Brazil of a broad investigation of mental health in urban populations. In the other cities that participated in the study, São Paulo and Brasília, the following indexes of global prevalence estimates and

potential demand of mental disorders were observed:

TABLE 6.2

Estimates of potential demand by diagnosis (DSM-III) , according to gender ,in three metropolitan areas. Brazil ,1990-1991

Metropolitan region:	Brasilia		Sao Paulo		Porto Alegre	
	Male	Female	Male	Female	Male	Female
Anxiety Disorder	7.8	16.4	4.3	9.6	5.2	5.6
Phobic Disorder	6.0	17.2	2.8	7.2	7.6	6.6
Somatodissociative disorders	1.9	9.8	0.7	3.0	1.7	3.9
Obsessive-compulsive disorders	0.5	0.4	-	-	1.7	0.7
Adjustment disorder	1.1	1.6	-	0.8	1.7	0.3
Depression	1.1	2.9	-	2.6	5.9	7.6
Mania and cyclothymia	0.5	-	-	0.4	1.7	0.3
Psychoses	-	0.4	-	1.2	3.4	0.7
Alcohol abuse/dependence	8.6	0.8	8.6	-	15.9	1.6
Mental retardation	1.9	2.0	2.1	1.2	2.4	1.3

5. COMMUNITY PARTICIPATION IN THE HEALTH SYSTEM

During the military regime, financial problems accumulated and several changes became necessary. As democracy returned, the channels of participation in political decisions began to reopen, and many changes were achieved in the Brazilian health system, both due to the pressure of popular movements and the unions and to proposals of reform by

Congressmen. The Federal Constitution of 1988 and the Laws of the Unified Health System (1991) reformed the system, enabling the municipal sphere to exert decisive and growing influence on health policies.

Thus, from the second half of the last decade onwards the municipal sphere of government gradually became more important in the system. The committees, and then the municipal health councils had the power to plan and supervise the use of financial resources transferred from the federal sphere of government to the municipal level.

Several mechanisms were created by the 1988 Constitution to operationalise popular participation in managing the system. Previously the users had been organised in a more centralised manner in municipal or even state entities or else through workers' unions. Although these entities were better organised than other more decentralised popular movements closer to the population, such as the Community Associations in each neighbourhood or low-income area that had their roots in the community struggles for health still in the nineteen seventies, several factors were accountable for the gradual change in the form of user participation.

Beginning with changes in the health system, Porto Alegre County gradually took over this new form of organisation and, working with the population, established the structures and form of management of this new system - the Regional Interinstitutional Health Committees (CRIS). Initially meetings were held during working hours, thus favouring the participation of representatives of health unit professionals and service suppliers, but making it difficult for the users to participate. All the same, several things were achieved, such as building new, equipped health units, especially in Porto Alegre areas where urban popular movements were stronger and better organised.

5.1 Legal changes

Several discussions were held with the executive level of government to regulate, by municipal law, the existence of the Municipal Health Council and, thus, the representations

in the different regions of Porto Alegre. The Municipal Health Council of Porto Alegre passed a Complementary Law in 1992: a Deliberative Body of the Single Health System, defining as its competence:

- to define the health priorities
- to establish and decide on guidelines
- to control the implementation of health policies
- to propose criteria for scheduling and financial and budget implementations
- to follow, assess and inspect the health services provided to the population
- to study and sign contracts and agreements between the public sector and private entities
- to define criteria on quantity and quality of health services.

The Municipal Health council is a collegiate organ constituted by representatives of the Municipal Government (Executive Power), health professionals, service providers and users. These representatives adopt the following distribution: half the places are for user representatives, and the other places are for government representatives, service providers and health professionals. The Council is also constituted by Committees, amongst which is the Mental Health Committee.

The Mental Health Committee was established in 1992, in response to a requirement in the Psychiatric Reform Law of Rio Grande do Sul. This Committee is concerned with planning, following , inspecting and evaluating the mental health policy in Porto Alegre, operating by delegation of the Municipal Health Council. It is constituted by representatives of the municipal, state and federal governments, professional classes related to mental health, public hospitals and hospitals working with the Unified Health System, unions, community, user and family member organisations. Some organisations are *AGAFAPE* (Schizophrenic Patients Relatives Association) and *Mental Health Forum of Rio Grande do Sul.*

5.2 Local Health Councils (CLS)

After the Municipal Health Council had been duly regulated, the CLS (Local Health Councils) were organised. These were at district level, which are currently the participative

forums closest to the population. The CLS are constituted by representatives of different organisations such as Associations of Inhabitants, Community Associations, Mothers' Clubs, schools and others. Besides planning, evaluating and controlling health in the region (neighbourhoods and/or low income areas) the CLS are beginning to have the possibility of managing the financial resources they receive, based on the organisation of Local Managers Councils. Currently, Porto Alegre is divided into 11 Health Districts, each District with a corresponding CLS. There is also a discrepancy in the health service network of each region or district, therefore each CLS is responsible for the social control of a different number of services.

The representatives of the various organisations that constitute the CLS meet monthly, in the evening, to provide an opportunity for the participation of the users' representatives to plan, discuss and evaluate health actions. From the beginning, co-ordinators were elected, responsible for organising the schedule of the meetings, the agenda according to topics presented by the group present and co-ordinating the meeting proper, besides representing the CLS at the Municipal Health Council (CMS).

The CLS can promote events such as local conferences, seminars and study rounds on the topic which seem relevant to the needs of the region. It is in the CLS that the most pressing needs of the population appear, and where pertinent actions are articulated for solution or referral. In democratic discussion demands are prioritised and solutions initiated.

5.3 Creating new social structures

Project Housing: The purpose of this project is to revert the trend to social isolation, strengthening ties with the family, the neighbourhood and the community at large. Housing should be considered temporary, depending on the individuality of each person. The project includes 2 programmes:

a) **Sheltered Housing** (Boarding House) *"Nova Vida"* (New Life): this is a residence, in a public building , with a specific team to provide care (nursing aides and "therapeutic friends") to benefit people with poor socio-economic resources. It was planned to shelter at most 20 persons with full care and connected to the CAIS Mental. At

present there are 20 persons, former inmates of psychiatric hospitals.

b) **Transition House** (*Casa de Transição*): it is a house connected to this programme for the purpose of developing skills in organising living and autonomy for mental patients who are psychically and economically capable of self-maintenance. The expansion of this programme includes the rental or purchase of houses or apartments for small groups (3 to 4 persons), who will be responsible for the daily maintenance activities of the home. The people who live in these homes will be connected to treatment at the CAIS Mental in the Workshops and helped to enter the labour market.

Special Municipal School Luís Francisco Lucena Borges: The school was founded in September 1990 , based on a different proposition than that of the other special municipal schools of the Municipal School Network, since its aim was to form a working group to care for children and adolescents who presented with development disorders. Actually, because of the demand for care this project was not implemented as intended. The school takes care of children and adolescents who present development disorders (autism, psychosis, hyperactivity) but began to receive a large number of children and adolescents who had other emotional problems associated with mental deficiency.

The initial work at school took place in the form of Teaching Workshops (Construction and Repair, Vegetable Gardening, Cooking, Arts, and so on). The pupils would arrive at school and meet to choose the workshop they wished to attend that day. It was a new teaching proposition for a clientele that was also different from that of the other special schools, both of the County and of the State, which take care only of mentally deficient children.

Over the years, the group of teachers with the managing team, employees, and family members realised that there should be **School Regulations** - the most important document in the school, because that is where the laws of this institution are. This document was constructed by the School Community with its 4 segments: parents, pupils, employees and teachers. Together with the School Regulations it became necessary to create the **School Curriculum**, which is currently organised into 3 formation cycles:

First Cycle : 4 to 9 years - Basic Learning
Second Cycle : 10 to 14 years - Schooling
Third Cycle : 15 to 21 years - Becoming Independent

The Curricular Complements seek to prepare both working and the insertion in regular education of the pupils who are able to do so, since the main purpose of this school is the integration of the individual into the culture.

Teaching care of children and adolescents with development disorders requires knowledge on emotional development from the teacher, but the "Special Education professional" trains specifically in the field of Mental Deficiency, therefore the teachers at this school have 2 nights of training work, in which they do planning work, studying and learn more about the theory of matters pertaining to the peculiarities of this clientele. This work is guided by a psychologist from the Municipal Department of Education (SMED), as well as others, both from the sector of education and health, needed to discuss the questions of cognitive development and the adaptation of the curricular contents to these pupils.

The families are seen fortnightly by a psychologist who, together with the school Advisors, holds groups in which are discussed matters regarding the development of these children and adolescents. It should be stressed that clinical care for the students is not given at school, but they have a psychiatrist, psychologist and audiologist available at a Community Health Unit. This care was obtained in 1996, but prior to this the families encountered great difficulties in obtaining attention for their children due to the lack of public health professionals who would see children and adolescents with these characteristics. Because the relatives and the school needed to make teaching work feasible the School Community made an effort to seek public funds in the mental health sector. Efforts to obtain them have not yet ended, since the city has many demands in the sectors of Education and Health which are continuously being discussed and argued over in the Participative Budget. Traditionally, demands in these areas, as well the for Social Assistance (Welfare), are not priorities, since basic sanitation, paving, housing are the most important claims.

The school's need to obtain public clinical care for the students began with the perception of the difficulty in performing teaching work with those who did not have this care available. It proved possible to perceive a great difference in the learning in students who had received systematic care from mental health professionals. Teaching work would be

impossible without this clinical support to the student. Although this finding had been made a long time ago by the school, it could be perceived that the recommendations for clinical care made to the families lead to real "pilgrimages" for them due to the lack of public means to provide Mental Health care. The families felt unstimulated and discouraged to continue looking and the most tragic consequence for the students was that the families would accommodate to the situation and stop seeking help. Therefore the school mobilised not only the whole School Community but also the community covered by Health District 7 of which it is part.

In this school there is participation by organising groups which seek to discuss the rights of children and adolescents with development disorders, in several forums, such as through the Participative budget, the Local Health Council, the Municipal Mental Health Council, since these are spaces for collective discussion where the policies and priorities for the use of public moneys in the city are defined.

6. INTEGRATION BETWEEN FACULTY AND HEALTH SERVICES IN TEACHING PSYCHIATRY

Porto Alegre has three Medical schools, two of them public and belonging to the Brazilian Ministry of Education and the other private, maintained by a Catholic religious organisation. All of them have Psychiatry and Mental Health Departments and Services. The Teaching Model varies from one school to another, but it is based on different frameworks of reference. We will describe the Model of Health Care, Teaching and Research proposed by the Department of Psychiatry and Psychiatric Service of the *Fundação Faculdade Federal de Ciências Médicas de Porto Alegre (FFFCMPA)*, in an agreement with the *Hospital Materno Infantil Presidente Vargas* (mother-child care hospital) (HMIPV); this is a broad Psychiatric Service which serves both the aims of the Hospital and those of the Medical School.

The HMIPV provides both secondary and tertiary care for women and children. In a way it treats a population of women who present with puerperal problems, as well as children and adolescents of both genders who are described as high risk. The hospital is generally

dedicated to the care of all diseases affecting women and children. For women care goes beyond gynaecological issues and involves other problems they may present, medical and general surgery and, due to their significance and frequency, psychiatry and mental health.

The Psychiatric Service was introduced in 1991, in response to the Law of Psychiatric Reform of the State of Rio Grande do Sul, which required the integration of Psychiatric Services to that General Hospital. It includes a 25 bed in-patient unit and an out-patient clinic. At first the OP clinic provided care for the patients who had been discharged from the in-patient Unit, and later to respond to the demand which has already become considerable, since the clientele sought to find the whole range of services they required in one place. Soon the Consultancy and Liaison and Community and Social Psychiatry Units were added.

The Psychiatric Department and Service actively train physicians; in the Undergraduate Course they develop disciplines and internships with families and in the community, the out-patient clinic and in-patient unit at the Hospital. The disciplines developed are oriented to the study of human life and personal development, the doctor-patient relationship and Clinical Psychiatry. In order to train Specialists in Graduate courses, teaching is organised under the form of Residency Programmes. These Programmes seek to contribute to train physicians and specialists providing them with knowledge of psychiatry and mental health. The academic and hospital psychiatric service that was being created adopted a programme and a structure that emphasised psychiatric and mental health practice where the biological, psychological and social fundamentals of population care had a counterpoint in teaching and research adapted to them. Therefore, the introduction of a strong community and social component in undergraduate and graduate training was a paradigm of teaching developed since the beginning of the programmes aiming to provide future and already practising physicians with knowledge, skills and attitudes allowing good psychiatric practice by non-specialists. From its inception the service was organised in an innovative manner, establishing agreements with the newly formed community mental health services.

Several teachers in the psychiatric department sought and are seeking postgraduate training

in M.Sc. and PhD. courses, aiming to form the teachers and researchers of the future. Research is expected to receive a strong impulse in coming years. The Head of the Psychiatric Service and Professor of the Department maintains a line of Research in Community and Social Psychiatry, Extension of Mental Health Care for Populations, and Social Aspects and Diseases. These are areas which concentrate interests that are essential to establish adequate Mental Health policies and to develop conventional and innovative Mental Health Services.

This organisation of Health Care, Teaching and Research with the common denominator of defined population interests, modifies the conventional organisation of Teaching and Research in Mental Health performed at conventional institutions of higher education. Knowledge regarding the population, the diagnosis of their health problems, and the definition of Health priorities to be fulfilled, as well as the need to involve the population in their care, require innovative forms of service and the use of adequate technologies able to maintain a high quality of care which can be provided to a large number of members of the population defined.

7. FINAL THOUGHTS

The care of individual mental health in a society could be considered an indicator of quality of life. Conversely, the tissue of factors which determine quality of life in a collective group, whether economic, ecological, educational, cultural and health care proper, affects the possibilities of promoting, preventing, treating and rehabilitating mental health. The challenges have been set in the City of Porto Alegre: a growing demand for health actions together with the need to advance in reforming the prevailing health system. The legal foundations have already been established, and it is up to the different levels of government to make more courageous investments and also and increasing participation of society in matters pertaining to mental health. However, mental health reform is not simply to reposition the functioning of services providing care to individuals in psychic distress, since it is founded on affirming this individual as a citizen able to interact with and contribute to constituting the social tissue.

REFERENCES

ALMEIDA FILHO, Naomar et al. Estudo multicêntrico de morbidade psiquiátrica em áreas urbanas brasileiras (Brasília, São Paulo, Porto Alegre) *Rev.ABP-APAL*, n.14, v.3, p.93-104, 1992.

BUSNELLO, Ellis D. et al. Morbidade psiquiátrica na população urbana de Porto Alegre. *J bras Psiq.*, n.41, v.10, p.507-512, 1992.

DIAS, Miriam T.G. *Os (des)caminhos da política de saúde mental no Rio Grande do Sul: uma análise da implantação da Lei de Reforma Psiquiátrica*. Dissertação de Mestrado em Serviço Social - PUCRS, Porto Alegre, 1997.

IBGE. Instituto Brasileiro de Geografia e Estatística. *Censo Demográfico 1991: resultados do universo relativos às características da população e dos domicílios*. Número 24-Rio Grande do Sul. Rio de Janeiro, 1991.

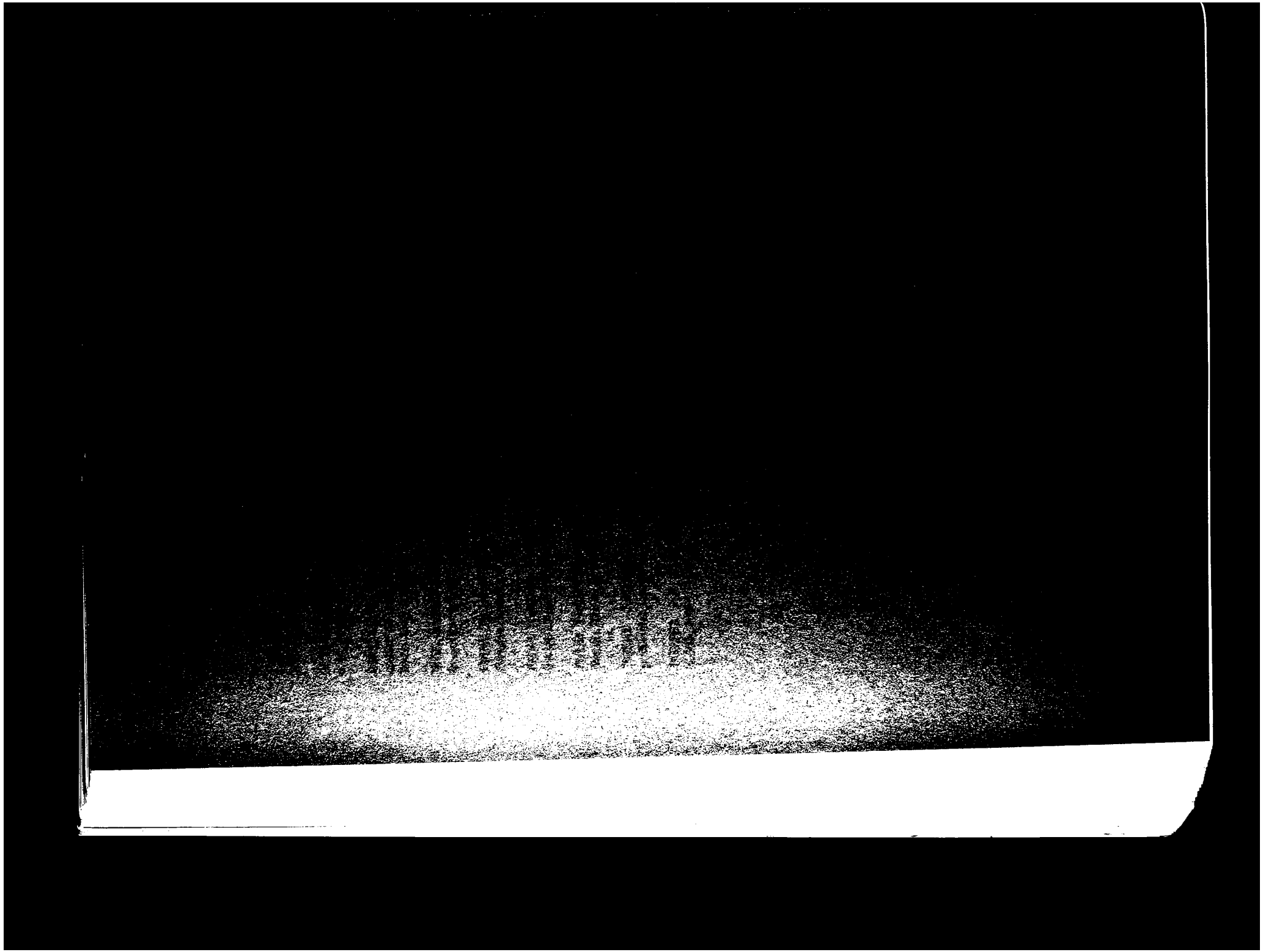
PMPA (Prefeitura Municipal de Porto Alegre). *Relatório de Indicadores Sociais de Porto Alegre*. Secretaria do Governo Municipal, ano I, dezembro de 1996.

PMPA (Prefeitura Municipal de Porto Alegre). *Porto Alegre e Sua História*. Coordenação de Comunicação Social. Coordenadoria de Relações Públicas, abril 1997.

PNUD. Programa das Nações Unidas para o Desenvolvimento. *Relatório sobre o Desenvolvimento Humano no Brasil*. Rio de Janeiro/IPEA; DF: PNUD, 1996.

PUCRS - FESC/PMPA.. *A realidade do morador de rua em Porto Alegre*. Relatório de Pesquisa - versão preliminar, janeiro de 1995.

PUFFER, R.R. & SERRANO, C.V. *Características del peso al nacer*. OPAS/OMS: Publicación Científico, n.504, 1988



CHAPTER 8

MENTAL HEALTH SERVICES IN SYDNEY, AUSTRALIA

Gavin Andrews[1] and Cathy Issakidis

(1) Professor Gavin Andrews
University of New South Wales
Clinical Research Unit for Anxiety Disorders
299 Forbes Street, Dalinghurst
NSW 2010, Australia

Tel: 00 61 2 9332 1013
Fax: 00 61 2 9332 4316

CONTENTS

In 1867 a 'Lunatic Reception House' was established in Sydney "to save innocent people who God has visited with this terrible calamity" being wrongly admitted to gaol. One hundred and thirty years later the service offers a full mental health service including a 24 hour mobile crisis team to the people of the inner-city. And Sydney is all the better for it.

1. THE CITY OF SYDNEY, AUSTRALIA

1.1 Brief History

Sydney was founded in 1788 when Captain Phillip arrived from England to establish a penal colony. His fleet landed in Botany Bay, which Captain Cook had described eighteen years earlier. Four days later they discovered the jewel that is Sydney Harbour, and located the new settlement there. Sydney was a convict town for sixty years but, despite its brutal beginnings, the city's mixture of pragmatic egalitarianism and plain indifference has transformed it into a thriving multicultural society, that is, wonderfully, a great place to live.

1.2 Sydney today: population & characteristics

Sydney, circa 1997, is four million people spread over the area of greater London. It stretches between the Pacific Ocean, across three glorious waterways, and up to a range of steep sandstone hills 80km inland. The climate (average temperature 22C, 1220mm rain, 114 clear

days) makes life easy, but the key is the vitality that comes from security and affluence. Rated the best place in Australia to live (Corrigan, 1997)] and rated by the Economist as the second best place in the world to live. It is a major world city, a financial capital, a manufacturing hub, a transport centre, and a centre for the performing arts. Intellectually it thrives. There are five universities, and the University of New South Wales, the source of this article, currently ranks first in Australia in terms of research productivity.

Life expectancy for Australians, despite the truncated expectancy among the aboriginal people, is second only to Japan. Infant mortality is 570 per 100,000. The population is aging (0-15 5%, 65 plus 14%), but not as rapidly as in many developed countries, in part because of the effect of waves of migrants from Europe, New Zealand, South America, and now Asia. Seventy percent complete 12 years of schooling, but those with less education find it more difficult to get work. The unemployment rate is 8.5%, but employment patterns are changing, with increasing proportions of the workforce being female and part time. Eleven percent are identified as living below the poverty line ($440 per week for a family of two adults and two children) and 32% are living on welfare benefits (aged pension 11%, invalid and sickness 3%, sole parent 3%, unemployment 6%). Social alienation is hard to define, but doesn't seem to be an issue; in one study of a suburb that was demographically typical, 90% of people considered that they could call on relatives, friends or neighbours to look after their family for a week were there a crisis (Andrews et al.,1977).

1.3 Sydney for the Disadvantaged

At many levels Sydney is a great place for the competent in society to live, but what about those who are disadvantaged? Housing: Home ownership is very high (70%) and no one would choose to rent on a long term basis. The State Government provides subsidized housing for the poor (2.2% of the housing stock) and a small proportion is reserved for the disabled poor, including those with mental disorders. Even so some people are homeless - defined as 'not living in one's own home and do not know where one will be living in two months time' - and

the morbidity in this group is considerable, the morbidity being an important risk factor for homelessness rather than the consequence. There have been a number of epidemiological studies of the residents of shelters for the adult homeless (16 beds per 100,000) that show that a quarter have met criteria for schizophrenia, and another quarter for cognitive impairment (Teesson & Buhrich, 1990; Virgona et al., 1993), many as a result of long term substance abuse. There have been no studies of personality disorders in this group. The number of beds per 100,000 for displaced children and teenagers is not known. There are 5 beds per 100,000 for displaced women and families. Missionbeat, a church organisation, picks up people who are homeless and on the street and conveys them to hospital or shelter as seems appropriate.

1.4 Drug Problems

Smoking marijuana is endemic, (13% have used in the last month) and, as the plant is easily grown, it is difficult to control. Opiates are freely available and can be obtained "as easily as ordering a pizza" say the newspapers, yet only 2% say they have ever used, and 1% have used in the past month. Cocaine and crack use is not significant. The significant drugs, in terms of health problems, are tobacco and alcohol, but the community is only gradually limiting the use of these legal drugs. They are beginning to realise that illegal drug use will not be eradicated by law enforcement and that strategies of harm minimisation might be more advantageous. Nevertheless the community cannot bring itself to conduct a randomised controlled trial of legally available heroin. There is a well funded Federal Government "Drug Offensive" which is mainly about education, and the State Government maintains a Drug and Alcohol Treatment Service that is separate from psychiatric services and on a one day census saw 35 per 100,000 population. Nevertheless the psychiatric services are expected to deal with people who are violent because of acute drug induced psychoses. They are, however, more concerned about young people with schizophrenia and bipolar disorder who self medicate with alcohol and drugs. "If I'm a drug addict" patients are reported to reason (Hannon, 1990) "then my hallucinations will stop when I stop doing drugs, whereas if I'm a schizophrenic I'm doomed". Dual diagnosis treatment strategies for young people are a feature of the better mental health

feature of the better mental health services.

Crime: Theft in metropolitan Sydney is high but assault (970 per 100,000 per annum), recorded drug offences (350 per 100,000), sexual offences (160 per 100,000) and driving offences (830 per 100,000) are higher elsewhere in the State. Rape and murder seem unacceptably high but the crime statistics do show that Sydney is not a particularly dangerous city (NSW Bureau of Crime Statistics, 1996 (personal communication)).

2. THE ORGANISATION OF HEALTH CARE IN AUSTRALIA

Australia's health system is largely funded by taxation revenue, both from general taxation revenue and from a specific 'Medicare' levy of 1.4% of all taxable income. The Commonwealth Government disburses the majority of these funds to the States and Territories to cover the cost of their public hospital and community services. Some of the Medicare levy is administered by the Health Insurance Commission which reimburses, on an agreed payment schedule, the cost of consultations with general practitioners and private specialists, the cost of pathology and radiology services, and, via a related scheme, the cost of a wide range of drugs. In addition, about one third of the population have private health insurance which offsets the cost of private hospital care, but not of doctors' fees. Mental health services, whether in public hospitals and community clinics, or given by general practitioners and private psychiatrists, are funded in exactly the same way, although the States also maintain a declining stock of stand-alone mental hospitals. In 1994-95 8.5% of the GDP was spent on health, with about one twentieth of this, nearly two billion dollars, being directed to the recurrent costs of mental health services, public and private, for mental and substance use disorders.

2.1 The National Mental Health Strategy

Until 1992 there was little attempt to co-ordinate the development of mental health services in each State or Territory but that year the health ministers of the States and Territories agreed to adopt a Commonwealth initiated six year National Mental Health Strategy to reduce the reliance on separate psychiatric hospitals, increase the focus on community based care, and to mainstream mental health care with other types of health care. This Strategy is in its fifth year and considerable progress is being made towards these goals, and towards increasing the funding available. In the first three years (National Mental Health Report, 1995) the total public sector inpatient beds were reduced by 11% to 40 per 100,000, the reductions being concentrated in the stand alone hospitals which now equal the general hospitals in bed numbers. The inpatient services are mainly general adult (65%), but 27% are designated psychogeriatric, 5% forensic and 3% child and adolescent services. The community mental health workforce in the same time grew to 23 community based direct care staff per 100,000 population. There are a total of 78 direct care staff per 100,000 in the public sector, so with 23 staff in the community only 35% of the total public sector expenditure is on community services, considerably short of the stated aim of directing half the expenditure into community services to ensure continuity of care.

The National Mental Health Strategy has also implemented a review of legislation to ensure that the relevant mental health acts are appropriate; it has established a National Community Advisory Group with State and Territory branches, but to date only one in three organizations have consumer advisory committees; and it has programs to ensure that consumers of mental health services have access to housing, community and domiciliary care services, and employment and training opportunities, from which they had been largely excluded. The Strategy has been active in reviewing the availability of trained staff and has sought to encourage private psychiatrists to focus less on long term psychotherapy and more on consulting for general practitioners. Schemes to increase the recognition and management of

people with mental disorders by general practitioners are being effected. The Strategy has been active in fostering standards for clinical practice both by encouraging services to routinely measure outcome and to gain accreditation from the Australian Council on Healthcare Standards.

2.2 Private Medicine

Private Hospitals, the majority being small acute stand-alone psychiatric hospitals, account for 15% of the total inpatient beds, and bring the total number of inpatient beds from 40 to 46 per 100,000. Their patients are less severe and have longer lengths of stay than the patients in the acute public sector units. There are 7.4 FTE private psychiatrists per 100,000. Private psychiatrists see 1.6% of Australians in a year, see most more than once (mean 8, median 3 sessions) a distribution that is skewed by long term therapy. Private psychiatrists are concentrated in the capital cities and this is a cause for concern.

2.3 Total Expenditure on Mental Health

Table 1 Distribution of recurrent spending on mental health services Australia 1994 - 95

State and territory funded public sector services	**61.2%**
Insurance funded private hospital services	**6.9%**
Commonwealth funded services and activities	**31.9%**
Private psychiatrists	**11%**
General Practitioners	**8%**
Pharmaceutical subsidies	**7%**
Veterans' services	**3%**
Mental health strategy	**3%**
Other	**1%**
Total (AUD 1.72 billion)	**100%**

In summary, Table 1 contains the pattern of expenditure on mental health from public and private sources for 1994/95. Australia spends 8.5% of the GDP on health. Mental health services, private and public, account for one twentieth of this total health budget ($1.72 billion, plus expenditure on drug and alcohol services). Of this two billion for mental health, 61% was spent by the States on public sector hospital and community services; and 32% was spent by the Commonwealth on patients seeing private psychiatrists (11%), on people with mental disorders seen by general practitioners (8%), on subsidies for drugs (7%), and on the mental health strategy (2%). Lastly 7% of the total mental health expenditure was spent by private health insurance funds on private hospital services. Direct treatment services for substance use disorders are not included in these figures.

Table 2 Prevalence of mental disorders by severity

Disorder	Serious mental disorder [a]	Chronic mental disorder [b]	Mild or transient disorder [c]	12 month total: any disorder	Mental problem [d]
Schizophrenia	0.5	0	0	0.5	NK
Any Affective Disorder	2.1	2.2	5.2	9.5	NK
Any Anxiety Disorder	1.2	2.2	9.2	12.6	NK
Any Substance Use Disorder [e]	1.0	2.2	6.3	9.5	NK
Total (% of population)	2.9	5.0	18.6	26.5	NK
Total Number (Australia)	0.5M	0.9M	3.4M	4.5M	NK

Notes:

a) 'Serious mental disorder' follows the NAMHC guidelines and includes all schizophrenia and related disorders, all bipolar disorder, 20% of major depressive disorder, and 20% of panic disorder and OCD, together with 10% of social phobia (that comorbid with avoidant personality disorder) and 10% of substance use disorder (principally drug dependence). At this level these disorders are chronic and disabling,

frequently lead to hospitalisation and require treatment by a specialist mental health or addictive service, or by a very experienced general practitioner.

b) 'Chronic mental disorders' are present, like the 'serious mental disorders', throughout the 12 month period and are associated with disability (i.e. global assessment of functioning (GAF) ratings of less than 70). They include 25% of all affective disorders, 17% of all anxiety disorders, and 21% of the substance use disorders. Substance dependence is treated by specialist drug and alcohol services in all Australian states but general practitioners have an important role to play in treating substance abuse. General practitioners should be competent to manage the other chronic mental disorders.

c) 'Mild or transient disorder': 70% of all people with mental disorders identified in the health surveys have disorders either so mild as to not handicap or else disorders that remit without treatment within the year. There are many human services outside the funded health system who already attend to such patients (Stress Management Programs, Counsellors, Psychologists and Clergy; self help groups and programs such as AA, other non government organisations) but general practitioners and specialist mental health services are often required to see such patients. They should either advise appropriately or refer to the non health system community services.

d) 'Mental Problems': Many persons with mental problems that do not meet criteria for a mental disorder attend psychiatrists and general practitioners. In the Epidemiological Catchment Area study 4.8% of the population sought services from these groups for social or emotional problems but did not meet criteria for disorder. About a third were subthreshold cases of anxiety or depressive disorders and a further third had met criteria for such disorders previously. Both these observations raise the issue as to whether health budgets should be expended in this way. As treatment is effective one would presume that, at least for the third who had once met criteria for a disorder, treatment may be keeping them well. Nevertheless inappropriate use of both inpatient and outpatient facilities was evident for a significant proportion of this 4.8% in the US data and has been demonstrated in Australia although it appears to be less frequent, even if more expensive, when it does occur. Again, Doctors should see and refer on or advise that no treatment is necessary.

e) As persons with one disorder tend to suffer another, the more severe the disorder the greater this possibility, and the totals have been discounted for this comorbidity, by 0.6 in respect to serious mental disorders, by 0.75 in respect to chronic mental disorders, and by 0.9 in respect to mild or transient disorders.

Now what does Australia get for 0.425% of the Gross Domestic Product expended on the treatment of patients with mental disorders? A National Survey on Mental Health and

Well-Being is being conducted during 1997 and the results are not yet available. However Andrews (1995) presumed that the patterns of morbidity would be similar to those shown in wave 2 of the US Epidemiologic Catchment Area Studies and in the US National Comorbidity Study and sought to relate data on the available workforce in Australia to the demand for services. The estimated prevalence of mental disorders by severity is displayed in Table 2. In terms of services delivered, only one third of the 25% of the population that meet criteria for a mental disorder in any year could, he decided, be receiving treatment from the health services. Of those that are treated, three quarters will be treated by general practitioners only, one eighth by private psychiatrists and one eighth by public sector mental health services (see Table 3). There was a marked disparity in costs according to the provider of services, with the public sector services costing four times more than the private psychiatrists who in turn were five times more expensive than the general practitioners. There was evidence that case severity paralleled this cost differential but was not a sufficient explanation. There were no data on outcome to allow evaluation of the effectiveness of treatment in the three sectors. Cost and effectiveness aside, the real problem is that half the people in Australia with serious mental disorders and one third of the people with chronic and disabling disorders are not being treated by any health service, despite the apparent adequacy on international benchmarks of staff levels, and despite the professional organisation of the services outlined above.

Table 3 **Relation between individuals with severe, chronic, mild of transient mental disorders; or mental problems; and the number (and %) of patients in these categories being seen by various sectors of the medical workforce for their disorders (all numbers as 000's).**

Disorder	Serious mental disorder	Chronic mental disorder	Mild or transient disorder	12 month total: any disorder	Mental problem
Total Number (000's)	**490**	**850**	**3162**	**4500**	**NK**
Public mental health service	**94 (41%)**	**33 (6%)**	**-**	**127 (9%)**	**39 (20%)**
Private Psychiatrists	**69 (30%)**	**92 (17%)**	**-**	**161 (12%)**	**69 (30%)**

General Practitioners	35 (15%)	402 (72%)	560	997 (74%)	153
Addictive Services	30 (13%)	30 (5%)	3	63 (5%)	NK
Total patients seen	228	557	563	1348	217
Per cent being seen	47%	66%	18%	30%	(100%)

3. THE ORGANISATION OF MENTAL HEALTH CARE IN NEW SOUTH WALES

New South Wales contains six million people, one third of Australia's population, and was recently rated the State with the best psychiatric services. Fuller Torrey and the US National Alliance for the Mentally Ill are well known for their ratings of services for the seriously mentally ill. Hoult and Burchmore (1994), in conjunction with the consumer group Schizophrenia Australia and the Clinical Research Unit for Anxiety Disorders at this Hospital, completed a similar analysis of the Australian public sector services for serious and chronic mental illnesses like schizophrenia. Information was sought by an extensive questionnaire from service providers, administrators and consumers. They rated New South Wales as the State with the best overall services: hospital, community, rehabilitation and housing. The Hoult and Burchmore survey identified the provision of 24-hour community-based services for the seriously mentally ill as the outstanding achievement of the Australian services. Every mental health service in Sydney (population 4 million) has an extended hours service which can undertake an emergency home assessment 7 days a week. Extended hours services on such a scale are rare elsewhere in the world. All this would be simple to understand except that New South Wales, the state with the best services, has spent less on mental health per capita than any other state or territory in Australia.

3.1 New South Wales versus the Rest of Australia

There is no clear explanation as to why the services in New South Wales, judged to be superior by Hoult and Burchmore, should be so, given the money expended. This has been a focus for discussion (Andrews & Teesson, 1996) and remains so, the figures in Table 4 being for 1994/95, the latest set available. This State spent the least money and put fewer dollars into community services, but somehow has the average number of community mental health staff, the average number of inpatient beds (albeit more in general hospitals), the average number of private psychiatrists, and the average number of general practitioners. The obvious conclusion is that some states get more than they pay for and in part this is probably true. However, New South Wales was the first state to embark on community care for the mentally ill on a substantial scale (Andrews et al., 1990a) and so has had time for such services to settle down and become efficient. But it also seems likely that New South Wales system of accounting might have underestimated the amounts spent on public sector mental health services. The figures in Table 4 are for 1994/95 but NSW Department of Health reports for 1995/96 claim that the per capita figure is now at the median value for Australia, $66 per capita, a triumph largely due to finding out where the money actually went (Muir, 1997), rather than to increased funding. What is of real interest, however, is that the present Economic Task Force reported that 80% of that $66, or $52 per capita, was utilised by the direct mental health services. And this is the issue of interest in the next section.

Table 4 **Excellence of service for the seriously mentally ill versus costs and resources for the six Australian states**

	NSW	VIC	SA	TAS	WA	QLD	AUS
Excellence Score	21	18	12	10	8	7	

PUBLIC SECTOR	NSW	VIC	SA	TAS	WA	QLD	AUS
Total Expenditure per capita	$49	$72	$66	$67	$63	$50	$58
(Exp on comm services)	($16)	($31)	($22)	($27)	($18)	($13)	($21)
Community staff per 100,000	23	30	28	23	21	16	23
Psychiatric bed per 100,000	40	34	46	53	42	37	34
% beds in general hospital	41%	22%	25%	33%	42%	37%	34%
PRIVATE SERVICES							
Expenditure on private psychiatrists per capita	$9	$11	$13	$8	$5	$7	$9
General practitioners per 100,000	118	120	125	124	111	115	118

The Centre for Mental Health in the New South Wales State Government is pursuing an aggressive policy to ensure that the 8% of the State health budget allocated to public sector mental health services are spent on those services; that the funds are progressively redistributed until equal amounts are spent on inpatient and non-inpatient services (this will mean a continuing reduction in bed numbers to 30 per 100,000, perhaps 20 acute beds and 10 longer stay beds); and that, while 70% of funds will continue to be spent on adult mental health services, the remaining funds should be split between services directed at child and adolescent, and aged persons' mental health services respectively. Clearly the good services provided by New South Wales that were noted in the Hoult and Burchmore report are to be maintained and improved by the new funding strategy.

South Eastern Sydney Area Health Service: New South Wales is divided, for administrative

and budgetary purposes, into seventeen quasi-autonomous area health services. They are autonomous in the sense that the chief executive officer gets the budget and is responsible for satisfying both God and Mammon; that is, the Department of Health on the one hand and the local providers on the other. South Eastern Sydney Area Health Service is one of these areas. It is responsible for providing public sector health care to 727,000 people spread across 300 square kilometers. The area is bounded by the central business district and the harbour to the north, the Pacific Ocean to the east, the Royal National Park to the south, and the rest of Sydney to the west. It contains the airport, the main port, the principal university, the centre for sleaze, and the oil refinery. But mostly it consists of hectare after hectare of detached dwellings of typical Australians - 17% of non-English speaking background, 13% over 64 years, 17% under 15, 7.5% unemployed, 37% with private health insurance. This Area Health Service receives $43 per capita to support the public sector health services, significantly less that the State average of $52. It has the expected number of general practitioners, private psychiatrists and private hospital beds.

3.2 St. Vincent's Hospital Mental Health Services

The South Eastern Sydney Area Health Service mental health services are deployed in four sectors. This report will focus on the Northern Sector in which St. Vincent's Hospital provides services to the permanent and transient inhabitants of the inner city, an area that now comprises both the central business district and the centre for sleaze. It wasn't always so.

History: In 1863, medical opinion was outraged that lunatics were admitted to gaol prior to being transferred to an asylum and called for the establishment of a "Lunatic Receiving House" where people could be assessed in humane surroundings and treatment started promptly. A pleasant building was erected and the first patients were admitted in 1868. Located adjacent to the police station and the court house, and across the street from the gaol, the Reception House functioned for 93 years as the only centre in the State for the triage of the mentally ill (Wallace, 1992). By 1961, when it was closed, it was admitting people at the rate of 10 per

day into what had become a 30 bed facility that concentrated on the prompt assessment and transfer of patients to a mental hospital, to a private hospital, or back into the community. By then, the emphasis on treatment in mental hospitals was diminishing and the emphasis on treatment in general hospital units with associated community services had begun. In 1961 the building was renovated and extended and reopened under the aegis of the Sisters of Charity as the Caritas Centre, a 36 bed psychiatric unit, part of St. Vincent's Hospital, a teaching hospital of the University of New South Wales. Over the years, the acute psychiatric service on this inner city site has played no small part in making Sydney a pleasant place to live, both for those that are well and for those who suffer from a serious mental illness.

In 1986 the Clinical Research Unit for Anxiety Disorders was established as a joint endeavour between the university and the hospital. In 1988 the small community health centre in the area was significantly enlarged and located in the old police station next door, the gaol across the road having become a technical college some 70 years earlier. The community and hospital services are in the process of being formally integrated even though they have worked as one service since the community clinic was relocated in 1988. In 1994 a liaison service to the general hospital was established and in 1996 a liaison service for local general practitioners was established. This conglomerate of services, the St. Vincent Hospital Mental Health Services, has all the usual paraphernalia of conglomerates - directors, deputy directors, business managers, research units, medical informatics units, catering units - likely to be of benefit to patients. Within the broad vision of St. Vincent's Hospital, the stated aim of the mental health services is to provide comprehensive mental health care to the residents of the inner city of Sydney.

4. THE TASKS, CIRCA 1997

1. Develop a hospital and community service to meet the needs of the local population

2. Develop a service to meet one of the State's need for Centres of Excellence in the common mental disorders

3. Develop a liaison service to meet the needs of the general hospital patients.

4. Develop a liaison service to meet the needs of the local general practitioners

5. Develop an educational program to support these initiatives

6. Develop a consumer liaison program so that the services continue to meet the articulated needs of consumers and voluntary agencies

7. Conduct research and evaluation on the quality of health outcomes

4.1 Task 1: Develop a hospital and community service to meet the needs of the local population

The local catchment area is small, some 72,000 population although when weighted for known risk factors it rises to the equivalent of 186,000 ordinary Australians. The demography of the area is that of most inner areas in large cities. While few people, apart from the wealthy in high rise apartment blocks, live in the central business district, the immediate surrounding area is densely populated. The old low rise buildings are a rabbit warren of shops, homes, small businesses, apartments, hotels, rooming houses, shelters for the homeless and premises used for prostitution and drugs. The contrast between the neat and tidy CBD and the sleaze to the east is marked. While the age standardized mortality ratios in the whole South Eastern Area Health Service are lower than the Australian norms, those in the Inner City Catchment Area are higher, and the excess mortality is due to drugs, AIDS, alcoholic hepatitis, and suicide, which probably describe the local population better than the following, dry population statistics. Compared to the rest of New South Wales the people in the area are less likely to be born in Australia (47% vs. 75%), less likely to be living in the same residence as five years ago (34% vs. 56%), more likely to be renting (57% vs. 25%) and more likely to be living in single person households (46% vs. 7%). There are fewer than expected children and aged. St. Vincent's Hospital, as part of the Mission Statement of the Sisters of Charity who operate the hospital, is active in ministering to this deprived population. The accident and emergency centre is very active, especially in the small hours. The drug and alcohol service runs a

detoxification unit, a treatment unit, a needle exchange and a methadone program. Two other religious orders offer housing support and there are 634 shelter beds for the homeless in the inner city. Thus there are services, it is simply that there is a big job to do, and part of this responsibility falls to the inner city mental health service.

Servicing the Local Population - The Inner City Mental Health Service

Budget: $5,450,000

Aims: the stated aims are legion and quite impractical. In practice the service is very clear that it exists to serve the needs of the region; responding to crises, offering short term hospitalisation and long term case management in the community, and doing what ever is necessary to maintain the deprived and damaged clientele as untroubled by their psychoses as possible. It is not, and cannot be, a resource for all whose mental state leads them to behave badly, no matter how desperately some would wish it to be so.

Structure: The physical structure was constructed in 1967 for voluntary patients and was not designed for the current clientele. The 27 bed inpatient unit is equivalent to 37.5 beds per 100,000, just under the present State average and probably appropriate given the high levels of morbidity in the area (equivalent to 15 beds per 100,000 weighted population, but there is no access to the 10 longer stay beds envisaged in the planning documents). The inpatient unit was constructed on land adjacent to the 1867 "Lunatic Reception House" which is now used as offices. The community mental health centre is housed in the adjacent 1867 police station, though the police cells which survive are used for storage and not for people. This mental health facility of community clinic and inpatient unit is separated from the main hospital by a small urban park and by the old gaol, about 400 meters, although it seems much further on a dark night. The service has 22 cars and sufficient mobile telephones to enable it to be a proactive outreach service.

Staffing: The Inner City Mental Health Service has 100 staff, 55% are trained psychiatric nurses, 18% are occupational therapists, social workers or psychologists, 10% are psychiatrists and trainee psychiatrists, and remaining 17% are non-clinical support staff. Many staff work on both the community and inpatient services but the community mental health centre has the full time equivalent of 50 clinical staff for a population of 72,000, three times the State and National averages, but on target at 20 per 100,000 weighted average, given the morbidity in the area. The inpatient unit is staffed at the State average for acute units, 1.2 clinical staff per bed. The aim of NSW Department of Health is to have budget expenditure equally divided between inpatient and community services. This is one service in which the budget is evenly divided.

Function: The inpatient unit functions like any acute inpatient unit, or at least like any

inpatient unit that services an inner city clientele. A census of a 1995 cohort of admissions (Boot et al., 1997) showed that 52% had psychosis, mostly recurrent, that 10% were from out of area and had gravitated to the area after becoming ill, that 16% were of no fixed abode, that 33% were admitted as involuntary patients under the various provisions of the State mental health act, and that 40% were brought by the police as being an acute danger to themselves or others. Using the Health of the Nation Outcome Scale, the staff rated the patients as very severe on admission, but considered that they had made one standard deviation improvement before discharge to community care an average of 10 days later. Compared to other units in the Boot et al study, this unit was the most efficient in terms of improvement per day of stay, a creditable achievement given such a severe and deprived clientele. To what can we attribute this achievement? First there was a close liaison with the community mental health teams, second there was a high level of professionalism among the staff many of whom had worked in the system long enough to know many patients well, and third that each patient was presented to all staff on a daily basis so that clinical decision making was informed and prompt. Last, the unit has a strong focus on educating each patient about their illness and the rationale for their treatment.

The Community Mental Health Centre is clever, and this originality has resulted in a number of awards for excellence. It was comprehensively evaluated 1990-95 by Teesson (1996). It functions in three teams with distinct roles, though of course there is a considerable overlap in what staff in each team actually do. The Crisis team responds to calls for help from police, medical practitioners, voluntary agencies, or from the general population. Always available, the crisis team can see people at the community mental health centre, at home or at the site of the crisis immediately, 24 hours a day, 7 days per week. If the person is known to the service or there is another health professional in attendance then one staff member can go, if the crisis is acute and emergency diagnosis and treatment may be indicated then two or three staff can attend, including the registrar. The Crisis team also services the hostels for the homeless in the area and, supported by Honorary Medical Staff, has, for a number of years, conducted evening clinics in the major shelters, assessing patients and prescribing the relevant medication. In an elegant time series analysis Buhrich & Teesson (1996) showed that these clinics had, after a period of increased case ascertainment, enabled people with psychosis, who would otherwise have been treated in hospital, to be treated in the community, even though they had no fixed abode. Teesson also showed that consumers and shelter bed staff were satisfied with the response of the Crisis team.

The Case Management team follows the clinical case manager model not the brokerage model (Andrews and Teesson 1994). The team is represented at the morning reviews on the ward and ensures that every patient resident in the area is assessed for suitability for case management prior to discharge. The team members take clinical responsibility for the day to day management of all patients (one day census, total case load = 630) liaising with the consultant as necessary. In a triumph of scheduling, every active case is reviewed by all members of the team at least every six months and, if necessary, a new management plan effected. Teesson (1996) followed 93 chronically homeless people with psychosis for one year and showed that while they are of no fixed abode they do tend to remain in the same geographic area. They are therefore appropriate for long term case management, even if finding them on any particular day might be problematical. This is where experienced case managers who know the area, do so well.

The third, or extended care and rehabilitation team, takes responsibility for the most severely ill patients and, in the absence of any long stay accommodation, manages them with a combination of intensive case management and attendance at a living skills and rehabilitation centre. Teesson and Hambridge (1994) showed that intensive case management was a cost effective option in general, and that even for such a disabled and deprived group, as that seen by the Rehabilitation team, it was cost neutral. Teesson (1996) also delineated the level of disability and the very slow response to rehabilitation in this group, and one might ask whether some of these patients might benefit from an intensive period of inpatient rehabilitation were such medium stay facilities available. Either way it is clear that the rehabilitation team is inhibiting deterioration and minimising harm from the violence and drugs which are prevalent in this part of the city.

The crisis team sees people in crisis, the case management team deals with those needing continued treatment and the rehabilitation team is concerned with people with end stage psychosis. The Inner City Mental Health Service has other initiatives which support these core activities. A small group are actively involved with young people with early psychosis and

seek, by caring about engagement, optimal treatment of psychosis, family intervention and maintenance of education or employment, to effectively alter the course of the illness. This is a new initiative and no results are available. One staff member is concerned with aboriginal patients and, as such, is unusual in Sydney, despite the considerable morbidity and mortality in this population. Another staff member liaises with the Non-Government Organisations which provide the bulk of the accommodation in the community for people disabled by serious mental illness, with the local consumer groups, and with Government and Non Government Agencies. The Service has also found it necessary to have formal agreements with the Police, and with the accident and emergency department of the hospital. Outcome is not yet measured as a routine even though it has proved quite practical to do so in specific studies on the ward and in the community clinic.

4.2 Task 2: Develop a service to meet one of the State's need for Centres of Excellence in the common mental disorders

In 1985 St. Vincent's Hospital, realising that the Department of Psychiatry was almost totally focused on the seriously mentally ill, took advantage of the offer of a small anxiety disorders unit's wish to relocate from another hospital, if only because that unit might broaden the reputation and educational experience available at the hospital. The psychoses are relatively rare diseases that commonly disable and when severe cause public affront and make it imperative that something be done. In the burden of disease studies schizophrenia and bipolar affective disorder account for 3.5% of the burden of human disease in developed countries like Australia. In contrast the anxiety disorders are common disorders, but because they are less likely to disable, and because the sufferers go to great pains not to cause affront to family or friends, the need for treatment appears minimal. Yet the burden of disease studies, which did not include the phobias, still found that the anxiety disorders contributed more to the burden of human disease (2.2%) than either bipolar affective disorder or schizophrenia. An anxiety disorders clinic and a mood disorders clinic should be part of every comprehensive psychiatric service if the aim of that service is to treat people disabled by mental disorders and not simply

to deal with medico-social emergencies. The New South Wales Department of Health has accepted, but not yet specifically funded, Centres of Excellence in the significant mental disorders. The Clinical Research Unit for Anxiety Disorders has been so nominated.

The Clinical Research Unit for Anxiety Disorders

Budget: $244,000 Clinic;
$240,000 research (external funds)

Structure and Function: The Anxiety Disorders Clinic occupies the cottage built for the Superintendent of the Lunatic Receiving House at the turn of the century. Situated between the old Receiving House building and the old police station it makes an excellent clinic. The clinic has a full time equivalent staff of five and specialises in cognitive behaviour therapy for people with anxiety disorders (Andrews 1996), and these treatment programs have been published (Andrews et al.,1994a). Only referred patients are seen. The clinic is a tertiary referral service and does not see people in crisis and does not offer stress management or long term counselling. It gives preference to people referred by psychiatrists and clinical psychologists. Seven hundred new patients, two thirds from outside the South Eastern Sydney Area Health Service catchment area, are seen each year and about half are accepted for treatment. The remainder are referred back to their doctor with advice about the appropriate diagnosis (usually depression presenting as an anxiety disorder) and treatment. Once people are offered treatment, of 20 to 80 hours duration, depending on diagnosis, most accept and 83% complete. Drop outs are very rare, a tribute to the excellence of the treatment (Hunt and Andrews, 1992). Outcome assessment, in part computerised, is a routine and the results are published (Hunt, 1997).

The Clinical Research Unit for Anxiety Disorders was developed on the idea that if one had basic researchers at one end of the corridor and clinicians at the other, and they all took tea together, then both would be informed. The model for this was the Burden Neurological Institute in Bristol that, 25 years earlier had had artificial intelligence people and neurologists occupy the same tea room in the hope that they would talk. To some extent this cross fertilization has happened in Sydney, increasingly the clinicians are doing their own basic research (Page, 1994; Hunt & Andrews, 1995; Crino & Andrews, 1996; Lindsay, Crino & Andrews, in press) and the six researchers, now funded by external grants, are active in other fields. The Unit has been made a World Health Organisation Collaborating Centre in Mental Health and Substance Abuse with special responsibility for diagnostic interviews and treatment protocols. As such it plays a central role in the WHO Composite International Diagnostic Interview; being responsible for the anxiety disorders modules, for the data entry program and scorer for the whole interview, and for the CIDI-Auto, a computerised version of the interview (Andrews et al., 1995; Peters & Andrews, 1995). It is currently funded to examine the

validity of the psychosis module of the CIDI and, if possible, improve it. The Unit has been active in the assessment of outcome measures (Andrews et al., 1994b; Andrews, 1995b) and has developed the interview for the current Australian National Survey of Mental Health and Well-Being. The epidemiological analysis of these data will inform the debate about the appropriate weightings for mental disorders in the burden of disease studies (Andrews & Sanderson, 1997) and for disentangling the burden in comorbid conditions (Andrews et al 1997). In terms of treatment protocols it completed the series on Treatment Outlines for Australian psychiatrists in 1992 (Quality Assurance Project, 1982, 1983, 1984, 1985a, 1985b, 1985c, 1990, 1991a, 1991b, 1991c) contributed to the World Health Organisation initiatives in this area (World Health Organization, 1991; Sartorius et al., 1993), has published a widely used text on the Management of Mental Disorders (Treatment Protocol Project, 1997), and is preparing a text on the management of acute inpatient units in psychiatry. Maybe taking tea with the clinicians was successful after all.

4.3 Task 3: Develop a liaison service to meet the needs of the general hospital patients.

The Division of Mental Health Services has always been pleased to offer a consultation service to the general hospital. It was simply part of the camaraderie of medicine. The haematologist or registrar came to see your patient and you or your registrar went to see their patient. Occasionally more time would be spent when the apparent needs of the general hospital fitted with the interests of one of the psychiatrists. In early years these special interests included the pain clinic and more latterly the neuropsychological manifestations of HIV/AIDS. In recent years, the Departments of Neurology and Neurosurgery were keen to use the psychometric evaluation skills of psychologists attached to the Division but not enthusiastic about paying for those services. Clearly the quid pro quo arrangement did not always work. In 1990, the College of Psychiatrists altered its training requirements to make a term in liaison psychiatry essential. It was time for firm action, especially as St. Vincent's was host to groundbreaking initiatives in heart and bone marrow transplantation, and in HIV/AIDS, all of which expressed the need for liaison psychiatric help.

The General Hospital Liaison Service

Budget: $330,000

Structure and Function: In 1994 a liaison psychiatrist was appointed, supported by a registrar on a training rotation, and two part-time senior nurses. In 1996 a formal liaison psychiatry unit was established, located within the general hospital, and latterly supported by a specialist psychiatrist (part-time), and a clinical psychologist. The current ethos is to emphasise early detection and the education of other clinicians to manage liaison cases themselves. However, in addition to the units mentioned above, Liaison now services the Accident and Emergency Service, seeing as a priority, people held overnight for psychiatric opinion. They also play a planned role in oncology, as well as responding to consultation requests from all hospital units.

4.4 Task 4: Develop a liaison service to meet the needs of the local general practitioners

Of the people in Australia who do meet criteria for a mental disorder and who see a doctor, three quarters see a general practitioner who diagnoses and treats without any specialist advice. General Practitioners find it difficult to form a consulting relationship with psychiatrists like they do with most other specialists, simply because psychiatrists are loath to take their phone calls. The Federal Government commissioned an inquiry (McKay 1996) which recommended a change in the payment structure for private psychiatrists so that they were rewarded more for consulting and less for continued psychotherapy. In another initiative, the Government made money available for shared care programs in which psychiatrists would meet regularly with general practitioners to discuss the management of general practice cases. The St. Vincent's Hospital Psychiatric Service, overwhelmed by the demands of the indigent psychotic patient has, until recently, stood back from any liaison with general practitioners.

A Liaison Service for General Practitioners

Budget: $220,000

Structure and Function: In 1996 a senior psychiatrist who was experienced in affective disorders and in shared care consultations with general practitioners was appointed to develop a general practitioner liaison program. The first steps have involved a continuation of the shared care consultations, now in respect to general practitioners in the catchment area; an exploration by videotape of general practitioner competencies in interviewing an actor simulating depression, and planned interventions with consultation and instructional materials to assist general practitioners in the

recognition and management of bipolar affective disorder.

4.5 Task 5: Develop an educational program to support these initiatives

The whole service is part of St. Vincent's Hospital, a teaching hospital of the University of New South Wales. A program of clinical training for fifth year medical students is undertaken and, at any time, nine students are doing placements in the various sections of the Service. Clinical placements are also offered to students of nursing and clinical psychology. The Clinical Research Unit for Anxiety Disorders has long felt that there is little point in excellence unless you teach others. For ten years they have taught medical students and trainee psychiatrists about the anxiety disorders, they have conducted workshops on issues of the day, such as Falloon's ideas about the management of the seriously mentally ill, and they have offered placements and courses to people wanting to learn what the unit does, whether that be the treatment of anxiety disorders, the use of the CIDI and the Personality Disorder Examination, or the measurement of outcome. For six years they have offered, as a University of NSW Masters program (UNSW, 1997), a two year part time course in psychological medicine for general practitioners. This masters program, which next year will be able to be taken by distance education over the internet, aims to teach general practitioners how to recognise and treat patients with mental disorders who present within their own practices. The course is restricted to experienced general practitioners.

Educational Programs: St. Vincent Hospital Certificate Courses

Budget: $45,000

In 1996 an education officer was appointed to organise a more comprehensive series of St. Vincent's Hospital Certificate Courses. The first courses were for psychiatrists and clinical psychologists in cognitive behaviour therapy and in recent advances in therapeutics; for nurses new to community mental health nursing in strategies of value in the community; and for all clinicians in topics as diverse as research methods, management of people with personality disorders, or the organisation of mental health services. In all 2400 person days are being offered to health professionals from all over New South Wales and to date they have been fully subscribed.

4.6 Task 6: Develop a consumer liaison program so that the services continue to meet the articulated needs of consumers and voluntary agencies

Australian mental health services were relatively unconcerned with the views of consumers or carers until they developed a political presence in the late 80's. The National Enquiry into the Human Rights of People with Mental Illness was, if anything, the turning point. There are now many strong advocate groups in mental health, both at the state and national level. The Commonwealth has established a National Consumer Advisory Group which has State branches and which takes input from the various organisations. To some extent these organisations reflect the traditional groupings and while there are advocates for schizophrenia and for bipolar disorder there are no advocates for unipolar major depression, the disorder of greatest burden. There were no advocates for anxiety disorders either until a group in South Australia founded the Anxiety Disorder Foundation of Australia. The anxiety disorders clinic at St. Vincent's Hospital was pleased to assist in the founding of a New South Wales branch which now is independent and has more than 800 members. There is a serious need for a similar body to represent people with depression.

4.7 Consumer Participation

Consumer representatives are now required for most federally funded programs, to the extent that most consumers who are at all active are being worn out by their commitments. The Inner City Mental Health Service has consumers on the two patient care committees which meet monthly. Consumers also attend the senior staff meeting. The Anxiety Disorder Clinic has a bill of patient rights and, by distributing copies of each treatment program at the beginning of treatment, ensures that each patient knows what to expect and can complain if certain elements of treatment are not made available. All patients are debriefed at the end of treatment, the responses recorded and identified problems rectified.

4.8 Task 7: Conduct research and evaluation on the quality of health outcomes

All sensible services should spend a fixed proportion of their budgets on research and development. To some extent teaching hospitals, in exchange for the cost of teaching students, have gained from the research ideas of the academics. But proper R&D is more than academic interest in new developments, it is about quality assurance that services are being run properly, and that health gains are being achieved.

Research and Evaluation Unit

Budget: $45,000

When the Community Health Centre was established in 1988 a research officer was appointed whose tasks were overseen by a triumvirate of two senior service personnel and an academic. Their task was to ensure that the research officer did not simply deliquesce into the CEO's personal assistant, into someone who only gathered data to answer the pressing questions of the day. Given such protection, the incumbent produced a body of quality assurance research (Teesson, 1996) that was fed back to, and influenced, the functioning of the Service. Donabedian would have been proud.

5. CODA

The Inner City Mental Health Service has adequate staff and facilities to provide an emergency psychiatric service to the people of the inner city. It does this well and one marker of success is that Sydney, unlike many other large cities, does not have numbers of apparently psychotic individuals shambling about. Sydney should be, and to a large extent is, grateful to the St. Vincent's Inner City Mental Health Service. What then are the problems? The principal problem is the rising tide of gratuitous violence among those being treated. Some of this is explained by the increase in the use of illegal drugs, especially amphetamines and steroids. But some is due to a change in societal perceptions of respect due to health professionals. There is an increasing shortage of nurses, doctors and other health professionals who want to work in public sector psychiatry and especially who want to tend to those who are chronically

psychotic. There is little evidence that treatment of chronic psychosis that ameliorates the acute symptoms well, materially alters the long term prognosis of the disorder and this, coupled with a difficult and dangerous work environment, makes recruiting good staff for New South Wales public sector acute services very difficult (see Roberts, 1995). To date staffing levels in the Inner City Service have been able to be maintained because of this Unit's reputation for excellence, and because the mission statement of the Sisters of Charity encourages like minded staff to serve. But fame and altruism are poor grounds for long term planning and this problem of the working environment will have to be solved.

The demand for the treatment programs offered by the Anxiety Disorders Clinic is overwhelming. About four times as many patients are referred as can be seen and treated. Even if there was money we would be reluctant to expand, fearing loss of quality control. Thus we tend to see only people who are suitable for and who desire treatment with cognitive behaviour therapy. Success has been a straitjacket and to some extent has narrowed the field of interest so that the Clinic is not as broadly based as a Center of Excellence should be. As a consequence we are deliberately branching out into the management of hypochondriasis, another of the Stress, Anxiety and Somatoform disorders.

While the desire of psychiatrists to be seen as part of medicine is understandable, the cost offset of providing a liaison service has never been completely clear. Mumford and others have published on the cost offset of psychotherapy in liaison psychiatry, and a number of papers have been written about the value of behavioural interventions in medicine generally (Mumford et al., 1982; Oldenberg et al., 1985). On the downside the existence of a liaison service often excuses physicians and surgeons from practicing whole person medicine with difficult patients - 'get the liaison fellow to fix it' is the cry. We have often wondered whether an educational program for physicians and surgeons might be more cost effective, and it remains to be seen whether the current emphasis on clinician education will prove fruitful. Nevertheless, the existence of liaison psychiatry encourages general hospital services to see psychiatry as the place where difficult people, and especially those with various types of brain

damage can be sent, a sort of oubliette for the patient nobody else wants. Given that the acute psychiatry inpatient unit has a mean stay of 10 days, a charter to deal with acute and serious mental disorders, and is replete with many wild and dangerous people, this hope is seriously wrong.

It is far too early to pass comment on the general practitioner liaison service, but unless the rift between general practitioners and psychiatry is bridged quickly we will see ill-informed treatment for half the people who meet criteria for a mental disorder and that, circa 1997, is simply untenable. More importantly, unipolar major depression was identified as the leading cause of disability, world wide, in 1990 (Murray & Lopez, 1996). New data on the poor outcome to be expected from the routine treatment of depressive illness (Andrews et al., 1990b) makes it clear that general practitioners who see the vast majority of cases will have to become very sophisticated in the management of this disorder if the level of disablement due to this treatable disorder is to be lessened. If burden of disease is any guide then we should be putting twice as much money into the treatment of unipolar major depression than to the treatment of schizophrenia. At present this service spends an order of magnitude less, but is better than most. At least it realises the problem.

The Education programs are, if attendance is any indicator, a success story. While people from outside St. Vincent's seem eager to pay to attend; St. Vincent's staff, being offered the course at no charge, seem less enthused, but then prophets shouldn't expect honour in their own country. On the bright side one would hope that people employed by other services who do do the courses would decide that St. Vincent's is an exciting place to work and so apply when vacancies are advertised.

Informed and articulate consumers are overworked and, while governments see that the appointment of a consumer representative to a project or treatment centre might absolve them of blame if something goes wrong, it is simply too much to expect of the available consumers at this point. There is another concern. The purpose of medicine is to get people well so that

they never have to see a doctor again. Identification with a consumer group can maintain the sick or damaged role, whereas the person might be better off being identified as healthy. All disorders benefit from pressure groups, after all the traditional method of funding is the same as last year plus or minus 5% for pressure groups. The problem is that not all people benefit from working for such pressure groups. Sometimes working for a pressure group is not the best way for a recovered patient to spend the rest of their life. Or for a grieving parent.

The Service is presently under considerable pressure to do more with less. Predictably the research officer is being consumed by the need to support the director. In the short term this is understandable, but in the longer term the service will benefit from an independent research initiative that seeks to develop programs to inform the service rather than simply answer current questions.

But to cavil is petty. Of course things could be better, but one needs some organising principle to know how to do better. The NSW Department of Health suggests that we spend 30% of our budgets on child and adolescent and psychogeriatric services adjusted to their representation in the population, so on that principle we should be apportioning some 15% of our budget to such services, or at least to supporting the general practitioners in dealing with these groups. We don't spend 15% of our budget and we could.

The WHO/World Bank project on the Burden of Disease has been very kind to psychiatry, showing that 24% of all disability is due to mental disorders and that 17% of the total burden of human disease, measured in disability adjusted life years lost, is due to mental and substance use disorders (ad Hoc Committee on Health, 1996). Furthermore they have argued (Bobadilla et al., 1994), that as no country can afford to meet the needs of the total population one should apportion health services according to the burden of a disease and the cost-effectiveness of dealing with it. Mental and substance use disorders account for 17% of the burden, but in Australia only get 6% of the total health budget. Clearly a substantial increase in funding is in order, even before we go into the cost-effectiveness of treatment.

Forget about the traditional funding model being the same as last year plus or minus 5% for pressure groups, let us demand a degree of equity.

Given the possibility of such a budget windfall, we should apportion it to the various mental disorders in proportion to their burden (affective disorders 8%, substance use disorders 5%, anxiety disorders 2% and schizophrenia 2%). At present the St. Vincent's Hospital Mental Health Services apportion at least 50% to psychosis and at most 20% to the depressive and anxiety disorders in total. And as such, this service is leading the way in terms of distributing resources according to burden. Nevertheless, one would hope to be able to apportion funds according to patient need, and not according to society's need to respond to demand or to limit affront. The burden of disease figures are first approximations and will surely change. Judging from our pilot data, the total burden of disease due to mental disorders will stay stable, while the relative importance but not the rank order of the disorders will change. That is, the largest burden will be due to the affective disorders and the most cost effective treatments will be those associated with the anxiety disorders. In burden and cost effectiveness terms therefore, more money should be spent on the depressive and anxiety disorders if the country wishes to be productive and rich. People who can be cured, but who remain disabled at home, are an affront to our humanity as well as being an avoidable drain on the economic well being of all. Which accords with our view of the purpose of specialist medicine, which is to heal people and never need to see them again.

REFERENCES

Andrews G. (1995) Workforce deployment: reconciling demands and resources. Australian and New Zealand Journal of Psychiatry, 29: 394402.

Andrews G. (1996) Talking therapies that work: the rise of cognitive behaviour therapy. Editorial. British Medical Journal, 313: 1501-1502.

Andrews G and Teesson M. (1994) Smart versus dumb treatment: Services for mental disorders. Current Opinion in Psychiatry, 7: 181-185.

Andrews G and Teesson M. (1996) Some get more than they pay for: mental health services in Australia. In M. Moscarelli, A. Rupp and N. Sartorius (Eds.) , Handbook of Mental Health Economics and Health Policy, Volume 1, Schizophrenia. JohnWiley & Sons Ltd: Chichester.

Bobadilla J-L, Cowley P, Musgrove P and Saxenian H. (1994) Design, content and financing of an essential national package of health services. In CJL Murray and AD Lopez (Eds.) Global Comparative Assessments in the Health Sector. World Health Organization: Geneva, pp.17-180.

Boot B, Hall W and Andrews G. (1997) Disability, outcome and case mix in acute psychiatric inpatient units. British Journal of Psychiatry, in press.

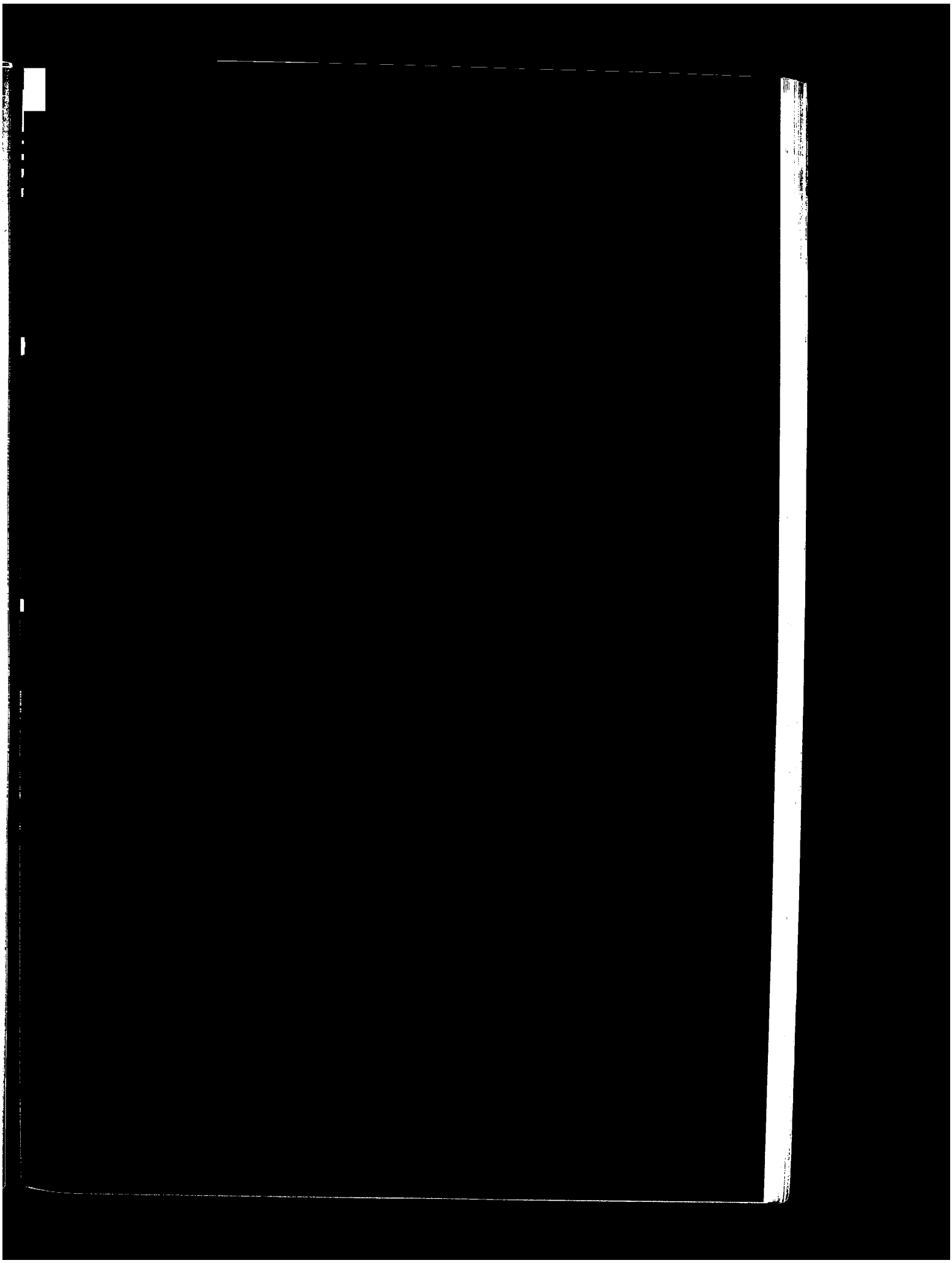
McKay B and Associates. (1996) Issues and Options: Optimum Supply and Effective Use of Psychiatrists. A Project for the National Mental Health Strategy. McKay & Associates: Melbourne.

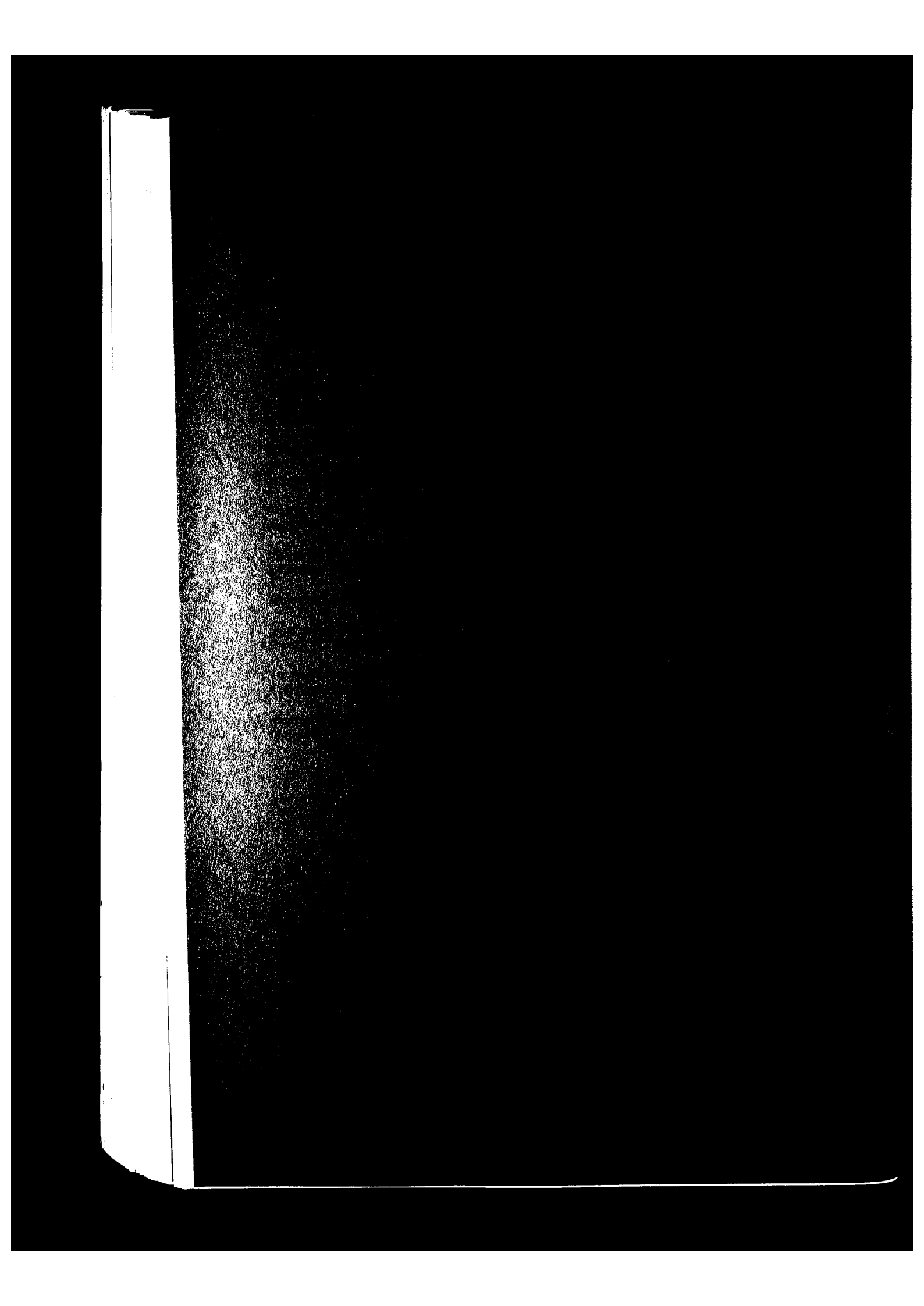
Murray CJL and Lopez AD (Eds.) (1996) The Global Burden of Disease. Harvard University Press: Boston.

The Quality Assurance Project. (1983) A treatment outline for depressive disorders. Australian and New Zealand Journal of Psychiatry, 17: 129148.

Treatment Protocol Project. (1997) Management of Mental Disorders. 2nd Edition World Health Organisation Collaborating Centre for Mental Health and Substance Abuse Darlinghurst NSW.

Virgona A, Buhrich N and Teesson M. (1993) Prevalence of schizophrenia among women in refuges for the homeless in Sydney. Australian and New Zealand Journal of Psychiatry, 27: 405-10.





CHAPTER 9

MENTAL HEALTH IN TEHRAN IN THE CONTEXT OF NATIONAL MENTAL HEALTH PROGRAM OF IRAN

Dr Ahmad Mohit

Regional Adviser, Mental Health
Eastern Mediterranean Regional Office
World Health Organization,
Alexandria, Egypt.

Associate Professor and former chairman,
Department of Psychiatry
Iran University of Medical Sciences
(Tehran Psychiatric Institute)
Tehran, Iran.

Fax: 00 20 3 483 8916

CONTENTS

1 GENERAL FACTS ABOUT IRAN

Iran is a relatively vast country located in south-western Asia. The area it covers is about 1,600,000 Sq/kms. Iran has a diverse landscape and climate. Over half of the area is covered by mountains, a quarter is desert, and less than one fourth arable land. The arrangement of the great mountain ranges of Alborz in the north and Zagross in the south and west is believed to be pivotal in shaping the country's diverse climate. This variety in the environment has entailed dramatic variations in the socio-economic and cultural state of the people, from the prosperous, fertile green fields and forests of the humid north; to the dry, unfriendly desert sands of the centre.

According to the last national census of 1996, the population of the country is 60,000,000, of which 60.4% live in urban and 39.6% in rural areas. The average size of the family is just less than five persons. The Iranian family of today can best be described as a family in transition from extended structure to nuclear arrangement, therefore prone to many stresses. The population is quite young and the average age is just less than 20 years. Recent efforts at population control have been quite successful, and the annual population increase has dropped from over 3.5 in 1986 to 1.4 in 1996. The overall literacy rate is 80%, representing 85% of the population in urban and 74% in rural areas. The literacy rate among women is close to 70%. There are close to 1,000,000 university students and 96% of children reaching school age, enrol in schools. Until recently, the country's economy has been oil-dependent, but during the last decade, both agricultural and industrial sectors have been gaining a share in the overall economy. As will be discussed later, the health system has also been going through a great improvement. The official language and script is Persian. More than 99% of the people are Muslims (91% Shiite and 8.5% Sunni), 0.2% are Christian, 0.07% Zoroastrian and 0.05% Jewish. Since the 1979 revolution the country's political system has changed from a kingdom to an Islamic Republic.

Iran is divided into 28 administrative Provinces *(Ostan)*. Each province is divided into a number of Districts of which the country has about 250, more than 500 cities, 600 towns and over 66,000 villages. The capital city of Iran, Tehran, is also the centre of a province with the same name. More than 10 million out of 36 millions urban Iranians live in the Greater Tehran Area, therefore

making it a major urban centre, or a so called *mega city*.

1.1 THE CITY OF TEHRAN

1.2 Natural location and history

The capital city of Iran, Tehran is situated on the southern slopes of the Alborz mountains that separate the Caspian sea from mainland Iran. The city lies at an average altitude of 1,100 meters above the sea level and is the largest and the most populous city in Iran. Tehran that means "warm slope," was a village in the suburb of the ancient Iranian capital of "Rey." Following the fall of "Rey" to Mongols in 1220 AD, the residents of this city moved to Tehran and the foundation for this small village to become a city was thus laid. The visitor of today's Tehran, can hardly believe the 9th century account of a historian of the same city. "Tehran is one of the villages of Rey with such untamed inhabitants, whom are not only insurgent against their governors, but are in constant clashes among themselves to the extent that traveling between its twelve quarters has become impossible and they are inevitably forced to build and live in underground dwellings resembling ant nests." The real growth and gradual distinction of Tehran started in the sixteenth century and reached its culmination in late eighteenth century when it was chosen by the founder of Qajaar dynasty to be the capital city of Iran.

During late nineteenth and early twentieth century, Tehran was the centre of dramatic developments of Constitutional Revolution that was the beginning of a long, and at times painful road, of constructing modern Iran. With the fall of Qajaar dynasty, a western model of re-structuring became the order of the day. It was in this city that Iran's first modern university and hospitals were built. Tehran became a famous capital during World War II, where Churchill, Roosevelt and Stalin had one of their most famous meetings. Once more it became famous during the Movement for nationalization of oil in early 1950s. Finally it gained its highest fame in 1978 when it became the centre of most important activities and demonstrations of the Islamic revolution. After the revolution and for the most part of the decade of eighties, Iran was involved in a war with neighbouring Iraq. The war had devastating effects on many parts of the country including Tehran that was a target of bombings and missile attacks and also a destination for many refugees. In

addition, there was the problems of neighboring Afghanistan and the flow of refugees from that country. Such conditions caused many disruptions in the life of the city. Therefore, it would not be an exaggeration if we talk of the years' 1980-1987 as the worst years of modern Tehran.

The war ended in 1988 and soon after, the programs for reconstruction of the country started. During the eight years of reconstruction, Tehran has gone through tremendous change. On the one hand the city is visibly cleaner. Large areas of green space have been created and an extensive highway system has eased the traffic. The construction of an underground railway is almost finished without foreign financial or technical assistance. Finally, a number of cultural centres and libraries have been built in all parts of the city, particularly poor neighborhoods of south Tehran. On the other hand, these developments have been accompanied by a dramatic change in lifestyle. Gradually, living in high rises is becoming the norm. There are new and huge construction sights visible everywhere. Many of these new dwellings are occupied by first or second generation young couples who have come to Tehran in search of a better income and a brighter future. Old, solemn houses with peaceful courtyards and gatherings of extended family members, are, for the most part, things of the past. Only the privileged few, or an odd old couple living in a rare, intact corner of a traditional neighbourhood can afford such luxuries. Tehran is thus in transition. Both as a city and population-wise it is relatively young. It doesn't enjoy the same charm, and rich heritage of history and culture of a city like Cairo or Isfahan. Tehran's main resource is dynamism of youth and a willingness to create an identity. With this come many stresses, and to face them there have been innovations. One of them is the adaptation of WHO's Healthy Cities Project (see section 4).

1.3 Demography

According to the most recent national census of 1996, the population of Tehran is about 7,000,000. However, considering many sub-urban areas and settlements around the city, it is safe to say that at least about 10,000,000 people depend on this city every day. According to the first official census of Tehran, taken in 1883, the population of this city was 106,482. In 1922 the city's inhabitants were 210,000. In 1939 this number was increased to 540,000. Tehran's population shows a three fold increase from 1,512,000 in 1956 to 4,530,000 in 1976. The population of the city in 1986 was

just above 6,000,000. The population of Tehran is quite young and the ratio of the age group 0-20 years of age is more than 40%.

In general, Tehran's affluent neighbourhoods are in the northern part of the city, and as one goes towards the South, inhabitants become more deprived. This is reflected in per-capita income, housing space, public facilities, educational and health facilities and the like.

Like all other major cities, provision of health care in Tehran is through a complex combination of public, private, insurance and special services, such as the ones for military personnel and their families. Distribution of these services is not even. Most of the population of poor and condensed areas is unable to use private services, and poorer neighbourhoods depend for most of their needs on governmental services that are overcrowded and strained. Another problem has been the lack of the equivalent of Health House and Health Worker *(Behvarz)* in the cities including Tehran until recently.

2 THE HEALTH SYSTEM

A brief but adequate description of Iran's general health system is imperative. It would serve as an introduction to the country's mental health system, which is built upon this rather extensive network in both rural and urban areas; including, to a certain extent, the city of Tehran.

Iran is a signatory to the World Health Organization sponsored Alma-Ata declaration of 1978, aiming at Health for All by the Year 2000. Moving in this direction during the past two decades, the country's health system and indicators have been improving steadily. This has been achieved through a network of Primary Health Care Systems in rural and urban areas and is being coordinated at the national level by the "Ministry of Health and Medical Education." This ministry is responsible for all aspects of planning, leadership, supervision and evaluation of health services in the country, including training of health manpower at all levels.

2.1 Provincial Level

At the provincial level, there are 32 *"Universities of Medical Sciences and Health Services."* In addition to all scientific functions and responsibilities of a university, they are in charge of all the health needs of a certain geographic area of the country. They function independently under the general rules and policies set by the ministry. In each province the health affairs are run by one of these universities. Only Tehran province is divided among three major universities. The executive authority of the chancellor of the university is exercised through his different deputies, including the deputy for health affairs.

2.2 District Level

Each one of such universities oversees the activities of the next level; that is, the *District Level.* The district is the smallest autonomous unit in Iran's Primary Health Care networks. The District is the most natural administrative level promoted by World Health Organization for health delivery. Each district is small enough for the staff to understand the major problems and constraints of socio-economic and health development...yet large enough a unit for developing the technical and managerial skills essential for planning and management..." In the Iranian health network, the executive units at district level are The Health House, Rural and Urban Health Centres, Rural Health Worker (*Behvarz*) Training Centre, District Health Centre, and District Hospital. All of these function under the directorate of the *District Health Network.*

2.3 Health Centres

The Rural Health Centre *(Markaz e Behdaasht e Roostaaei),* is a village-based facility that supervises the health affairs in its own and a number of other Health Houses in neighbouring villages. On average, each Rural Health Centre covers the health needs of about 9000 people, and there are about 2000 functioning Rural Health Centres in the country. Apart from a physician, the staff of a fully established Rural Health Centre includes technicians for family health, disease

control, environmental health, oral health, laboratory, nurse aid(s) and administrative personnel. All the staff function under the doctor's leadership. The Rural Health Centres provide out-patient care and case finding among patients referred from Health Houses. They advise Health Houses on monitoring and follow-up. They supervise activities in the areas of family health, disease control and environmental health. They offer oral health services, participate in health projects and support their assigned health houses in their needs. They also have certain mental health responsibilities that will be discussed later.

2.4 Health Houses

The Health House *(Khaneh e Behdasht)* is the grass root health facility in the rural areas. Each Health House is capable of serving about 1500 people, though it is by no means an inflexible limit. There are about 15,000 such Health Houses in the country with about 28,000 *Behvarzes* working in them. Many Iranian villages have populations of less than 1500. Therefore, to ensure cost-effectiveness, each Health House covers one or more satellite villages as well as its main village. The distance between the main village and each satellite village is defined as being no more than one hour's walk. Each Health House has one (or more) male and one (or more) female Health Workers *(Behvarz.)* Each Behvarz comes from the same village he/she will be stationed later. The main function of a Health House is to offer primary health care services to the community it serves. A well-established Health House has some other tasks. These include annual health census, public education, a wide range of family health activities including immunization, family planning, disease control services. Environmental services and collection and reporting of health information are among the other tasks. As will be discussed later, Health Houses have well-defined responsibilities in the area of mental health. The following is how one of the people who has devised the Iranian health system has summarized the important role of Health Houses: "The Health House... effectively bridges a serious gap that persisted in Iran right up to the expansion of Primary Health Care (PHC) networks. Before this versatile health care facility was created, the provision of services to the most deprived rural communities on the scale and of the quality now attained, was neither feasible, nor conceivable."

As it is true in many other parts of the world, provision of health services to the urban areas has not been as easy and straightforward. There are different and competing private, semi private and governmental health providers in the city and bringing all of them under one umbrella like the one in rural areas is impossible. Even in the government sponsored networks, urban areas lack a grass root facility like Health Houses. It is only recently that some innovative ideas are being developed to find a replacement for this community based system. These include the use of different volunteer neighbourhood groups, among which the ones connected to *Healthy City* projects are gaining importance. The official equivalent of Rural Health Centre in the cities is the *Urban Health Centre (Markaz e Behdaasht e Shahri),* which performs the same type of functions for a population of 12,000. There are about 2000 of such centres in the country. All medical students spend a part of their training in different levels of Primary Health Care (PHC) fields.

As a result of the implementation of the above health system in Iran, Infant Mortality Rate has dropped from 145 per thousand live births in 1960 and 91 per thousand live births in 1974 to 28 per thousand live births in 1997, and is steadily decreasing. Major infectious and nutritional diseases are controlled. The rate of vaccination for common childhood infections (designated by WHO as *Extended Program of Immunization (EPI) target diseases*) is above 95 per cent. Overall life expectancy is 69 years, compared with 57 years in 1979, and Total Fertility Rate is down from 6 in 1974 to 2.6 in 1996.

3 MENTAL HEALTH

3.1 General considerations

Mental Health and care of psychiatric patients were, until the late seventies, provided through traditional psychiatric hospitals. A few such facilities existed in different parts of the country and offered traditional, mainly in-patient services to the those who could reach them. No concept of comprehensive mental health services existed and no facility could be found outside a few large cities and metropolitan areas. The first university psychiatric ward was opened in a general hospital

belonging to Tehran university in the forties. In the early fifties this ward was moved to *"Roozbeh Hospital"* and it became the first teaching psychiatric hospital in the country. The idea of "Community Mental Health" was introduced for the first time in the mid seventies. Then, the newly established "Society for Rehabilitation of the Disabled" started to designate catchment areas and develop outpatient treatment through community mental health centres. Simultaneously, new comprehensive mental health centres were built in different parts of the country, and the returning of treated patients to the community started. Many of these efforts continued after the revolution through a newly established "Tehran Psychiatric Institute." This institute was the main technical adviser of the ministry of health when the implementation of "Iranian National Mental Health Program" started in the mid-eighties.

The country has about 600 psychiatrists. The distribution of these psychiatrists is still not ideal. Tehran and a number of other large cities get a disproportionate number of psychiatrists. This uneven distribution was worse in the past. However, in recent years, through a series of regulations and the introduction of certain incentives, more specialists including psychiatrists are being attracted to work in deprived areas of the country. Therefore, nowadays, psychiatrists practice in all the provinces and many districts. Psychiatry is being taught as an independent subject in all medical schools, and all the students have mandatory clinical psychiatric training. Policies regarding internship in psychiatry differ in different universities, but it is mandatory for one month only in some universities. Curriculums of medical schools contain mental health and community psychiatry subjects, but still there is resistance for more changes. There are 10 psychiatric residency programs in the country. Together, they have a total of more than 100 resident physicians under training. One program in (Shaheed Beheshti University of Medical Sciences) offers subspeciality training in child psychiatry. Certification is undertaken by a national board through an examination consisting of written, verbal and clinical aspects.

The utilization of general (Bachelor of Science) psychologists in mental health services started before the revolution, during the time that psychiatric services were being reformed by the "Society for the Rehabilitation of the Disabled." Postgraduate training in clinical psychology started in the

early seventies and first degrees (of Master of Science in Clinical Psychology) were awarded by Tehran university. The MS degree program of Tehran University stopped for a while after the revolution and a new program started in Tehran Psychiatric Institute. At present there are 4 programs awarding the degree of Master of Science in clinical psychology. The first Ph.D. Program in clinical psychology has also recently been opened in Tehran Psychiatric Institute. Training in MS degree for psychiatric nursing exists and mental health subjects are included in the curriculum of all nursing schools. The country has schools for occupational therapy and social work. Recently an MS degree for psychiatric occupational therapy has been introduced.

In the area of research, the first serious epidemiological studies were done by Bash and Bash during the fifties. Other research activities were initiated by Davidian. A major epidemiological study was also being undertaken before the revolution, and stopped afterwards. During the 8 years' war with Iraq a number of studies were also undertaken on different aspects of war-related mental health problems and PTSD. During recent years a qualitatively new era in research has started. This is characterized by the institutionalization of research in the work of an increasing number of post-graduate students. This is shown in a better quality of theses being written, and by improved supervision. However, research still has a long way to go and one major obstacle is a low degree of familiarity and emphasis on foreign language, and a low level of access to major global centres of research.

3.2 National Mental Health Program

The drafting of the National Mental Health Program of Iran took place in 1985. The program was then offered for approval, which it received in 1986. It was the product of a technical collaborative activity with the World Health Organization. It was also the result of a joint effort, in which Ministry of Health and three universities of Iran, Mash'had and Tehran were involved. The group was convened by Tehran Psychiatric Institute.

The objectives of the program are as follows:

(i) To make basic mental health services available to all the people in the Islamic Republic of Iran in near future. The emphasis would be on the most vulnerable and deprived groups in urban and rural areas who, so far, have not received any services, especially ones living in remote areas.

(ii) To produce a model of mental health services compatible with social and cultural structure of Iranian society and encourage community participation in building mental health services.

(iii) To increase people's knowledge and skills of mental health in the service of improving general health. To encourage the people in the direction of wider use of mental health principles in order to promote health. To accelerate socio-economic development and improve the quality of life.

(iv) To plan appropriately for provision of necessary mental health care for all who have in one way or another suffered mentally during the current war.** (i.e.: The refugees, the homeless, the disabled, the bereaved and the mentally ill), and to plan for long term services needed to face the consequences of this war in the future.

The main strategy of this national program is "Integration of mental health into primary health care system" through a set of strategic actions in the areas of Services, Training and Administration. *Division of labour* based on a clear understanding and definition of *Levels* is another principle of this program.

At the level of Health House (health post in the cities), the multipurpose health worker (*Behvarz* in the villages and volunteer in the cities) is given the following tasks:

- Alertness to the presence of mental and psychological symptoms and complaints as health problems.
- Understanding and ability to diagnose four common conditions of minor mental illness, major mental illness, mental retardation and epilepsy.
- Referral to the general practitioner and receiving back referrals for follow-up.
- Enough familiarity with psychiatric treatments (i.e., medications and their major side effects), for the purpose of follow up.
- Common understanding of stress related conditions and simple stress reduction methods. Also having some knowledge regarding the effects of psychological factors on

physical illnesses and vice versa particularly in vulnerable groups like adolescent, children, pregnant women and the elderly.

At the level of health centre, the general practitioner is in charge of the following tasks:

- Receiving referrals from the health houses and/or volunteers.
- Familiarity with major psychiatric conditions and their treatments with particular emphasis on common psychiatric illnesses. Initiation of drug and supportive treatment for psychosis, epilepsy, depression and severe anxiety states with required knowledge of the drugs and their effects and side effects.
- Referring those cases that need specialist's intervention to clinics and hospitals.
- Supervision of the work of family health and disease control technicians.

A disease control technician of the health centre supervises the health workers *(Behvarz)* in case finding and referral. She or he also helps the general practitioner regarding referrals and back referrals, and keeps the statistics.

The duties of family health technician are:

- Supervision of the health workers in establishing supportive relation with the families and the community
- Training of the *Behvarz* in areas of school mental health, problems of mothers and children and simple preventive measures.
- Mental health education for the community and family alone with the B*ehvarz*.

Supervision for the work of rural and urban health centres is provided by the psychiatrist or a specially trained general practitioner who is connected to the District Health Centre. The program envisages that each district general hospital would at least have 5 psychiatric beds. This aim has not been achieved in most hospitals.

Higher level supervision is being provided at provincial level through universities of medical sciences and at national level through directorate general for disease control. Technical guidance for this directorate comes from the national Mental Health Advisory Committee.

The Integration of Mental Health into Primary Health Care System started as two pilot projects in districts of *Shahreza* and *Shahr i Kurd* in 1987. Since then it has been continuously going on and growing in all parts of the country. At present the program is active at least in one district in each of the country's 28 provinces. In a number of provinces such activities exit in all districts. Throughout the country, 2998 Health Houses and 914 Rural Health Centres are active in this area. More than 6000 *Behvarzes* and 2000 General Practitioners have been trained. Although the integration in urban areas lags behind, it is hoped that with approaches like the one in Tehran and a similar one in Isfahan it would it would become possible to help it flourish.

The mental health activities in Iran have been visited and evaluated by different international experts. An official evaluation was done in 1995 by world level experts. The results of this evaluation clearly show the success of the program in general. The evaluation also is mindful of the shortcomings and the problems the program may face in the future. It has given a set of recommendations for the future expansion. It cautions against burn-out syndrome of field personnel and questions related to sustainability.

3.3 The City of Tehran's Mental Health Services

The city of Tehran uses the services of 300 psychiatrists, about 2600 psychiatric beds, four 'Government Psychiatric Hospitals' and three psychiatric wards in general hospitals. Two child psychiatry services exist that are connected to the universities. Five private psychiatric hospitals are also active in the city. The services for mentally retarded and the elderly are provided both through welfare organization and the private sector. A number of private general hospitals also admit selected psychiatric cases. Three universities of medical sciences in Tehran offer residency programs of psychiatry, one centre offers a fellowship program in child psychiatry. Two master's degrees and one PhD program in clinical psychology also exist. There are also programs for the training of social workers and occupational therapists at BS and MS levels.

The major psychiatric hospital is a classically huge institution (1700 beds) called *"Razi Psychiatric Centre"*. It is located in the southern suburbs of Tehran in a working-class neighbourhood and is surrounded by two cement factories. It is being run by Welfare Organization. Its general condition is clean and reasonably well kept, the basic needs of patients are met well, medications and other treatment modalities are available. But the philosophy that governs it is institutionalization. Up to now, all efforts to break it into smaller units scattered in different parts of the city have been unsuccessful. In the past this hospital was offering services to many parts of the country, but in recent years almost all the country's provinces have some psychiatric facility, and the reliance on this hospital for other parts of the country has decreased. It has some affiliation with different universities and some teaching and research activities are conducted there.

Other psychiatric hospitals and wards in general hospitals mainly belong to the universities of medical sciences. Among the university hospitals, mention should be made of *"Roozbeh Hospital"* which is the oldest teaching psychiatric hospital in Iran, and perhaps in the middle east. The Army, Navy, Air force, Police and National Bank have their own psychiatric services. There is a widespread network of school mental health activities that mainly focus on prevention and promotion. A special out-patient service exists for university students.

Services for drug abuse are all under government control. Addiction is regarded as a criminal act and addicts are admitted to facilities supervised by the police. Recently, the welfare organization in collaboration with the ministry of health and "Central Bureau to Combat Addiction", have started new programs in this area. Preventive activities exist through schools, media and "Healthy City Projects."

4 THE W.H.O HEALTHY CITIES PROJECTS

Healthy Cities is the name of an environmental health initiative of World Health Organization. The projects with this name aim towards continuous promotion and improvement of different aspects of health in urban settings through conscious, direct and volunteer involvement of the people and

intersectoral collaboration at national and local levels. The concept was introduced in Iran in 1990. The initial project started in one of the most deprived areas of south Tehran in February 1992. As the first activity of this project, the needs and expectations perceived by the people were collected through group discussion with 160 people selected through a systematically randomized sample of all the family files existing in the area's Urban Health Centre. These persons were invited to attend a meeting for discussion of the needs of their neighborhood. Ninety-five out of 160 people who were invited actually attended the meeting. They were then divided into ten groups, and each group was given the task of identifying what they would expect the Healthy City Project to do for them. Their suggestions and expectations were then systematically classified. It was based on these suggestions that the following seven committees were formed to plan and implement the programs:

- General Health
- Education
- Urban Services
- Employment and Income Generation
- Sport
- Community Participation
- Mental Health

The committees started to meet at least once a week, very soon to plan, and then to implement a range of activities in their respective areas. The detailed description of every activity is beyond the scope of this chapter and the following are some highlights:

General Health Committee: Experts from the ministry of health and medical education plus a number of community representatives are members of this committee. The most successful program of this committee is *The Health Volunteers*. These volunteers are mainly women who are known in the neighborhood to be sociable, intelligent and ready to assist other people. Their duties are very similar to the duties of *Behvarz* in rural areas, and include issues like vaccination, breast feeding, control of diarrhea, family planning and selected environmental health activities. It is through the same volunteers that a part of mental health services is also provided. Use of volunteers has been an innovative approach that could feel a great existing gap in provision of health to urban dwellers, the gap that was filled in the villages by *Behvarz*.

Education Committee: The members of education committee are experts from the ministry of education, teachers of different levels from the community, university students living in the

community and a number of interested persons. One of their most successful programs have been School Health Volunteer *(Behdaashtyaar e madreseh.)*. These volunteers' students are interested in health activities and are trained to function as health agents in the school and community. The activities of these students have been observed by a group of WHO consultants who evaluated mental health programs in Iran in 1995. The following is quoted from them: "The first thing that greeted us was the bright and clean school environment. Soon, we were met by well dressed, cheerful young girls. They were keen to share their activities. Initially they presented their work focusing on their different committees for health, school environment, nutrition, etc. On inquiry, they shared how their own attitudes and actions, along with that of their family members have changed due to the school health initiative. The aspect that remained with us, of the visit, was how well health related matters were integrated into the educational life and the value of such an approach. The beneficiaries are the children and the citizens of the city."

Urban Services Committee: Members include experts in urban development, city planning, architecture, environmental health, traffic management, green spaces and a number of interested people from the neighborhood. They work in close collaboration with schools and other community resources. This committee needs serious co-ordination because at times it deals with opposing views and interests. This committee's activities include making the streets user-friendly for the disabled, and beautification of neighborhood and schools. Comprehensive planning for protection of green spaces and public parks and gardens by the community is among their other activities.

Committee for employment and income generation: experts from Welfare Organization, ministries of labour and education and some members of the community are among the members of this committee. They have been active in finding the cases of unemployment, provision of training and finding proper jobs for many of them.

Committee for sport activities: Members are from the National Organization for Sport and interested community and neighborhood volunteers. They have been able to build sporting facilities and organize regular matches among 18 football teams competing for the Healthy City Cup.

Committee for Mental Health is an innovative committee of the Healthy City Project in Tehran. The activities of this committee will be described in detail in this chapter.

4.1 Mental Health Component Of Healthy Cities Project In Tehran

As has already been described, the national mental health program of Iran was more successfully implemented in rural areas. One of the main reasons for the difference between the two areas was the lack of first level support in urban settings. Healthy City Project and *Neighborhood Health Volunteers* provided an alternative.

The Tehran Healthy City initiative is based on the recognition of the following:

(i) Vast needs
(ii) Poor utilization of available services
(iii) Lack of community feeling
(iv) Limited resources
(v) Potential of people to act as agents for change

The above issues were creatively addressed by active involvement of the people in the programs. The general population became active partners rather than passive recipients. By making mental health a people's program, not only do all mental health needs get attention, but also the programs do not become highly dependent on institutions and scarce high level professionals. A community then gets an opportunity to plan for better utilization of these professionals. There is also greater scope for prevention of mental illnesses and promotion of mental health.

4.1.1 Objectives

The main objective of the program is to provide the necessary mental health services to urban, sub-urban and slum dwellers; by using the possibilities of healthy city projects including *Neighborhood Health Volunteers*. Specific objectives are:

1) promotion and increase in knowledge and attitude of urban and sub-urban dwellers regarding mental health.

2) Improving the attitude of people living in the cities and sub-urban areas towards psychiatric illnesses through continuous mental health education.

3) Case finding for neuro-psychiatric illnesses.

4) Proper and timely intervention in the areas of treatment, and follow-up for the cases found through the system.

5) Active delivery of mental health services in the areas covered by each project.

4.1.2 Administrative Strategies

- Formation of a mental health committee composed of the chief, District Health Centre, a consultant psychiatrist functioning as the main scientific and administrative adviser, psychologist, the officer responsible for preventive medicine, a representative from Welfare Organization and representatives from community based on their interest, willingness and possibilities to assist.

- The establishment of Health Posts *(paaigaah e behdaashti):* Health Posts in the cities would replace health houses in then villages. Such posts are being established in relation to Urban Health Centres, mosques, professional societies and other volunteer organizations and each of them cover a population of approximately 10,000 people. The health Posts are the centre of activity of the volunteers. Each volunteer provides a defined number of health services, some related to mental health, to a part of this population in 30-50 families.

- Each health post is administered by one of the volunteers. She functions as the guide and coordinator for others and maintains the link between the volunteers and their responsible officer in the Urban Health Centre.

- The establishment of a referral system. Such a system would provide referral from the community (where family, teachers and health volunteers are), to the Urban Health Centre (where the General Practitioner is.) It also makes provision for referral to and from the District Mental Health Clinic and Psychiatric Centres (where specialist resources and services are).

- Constant supervision of all levels.

4.1.3 Division of work

The duties of General Practitioners, experts and technicians are the same as the ones described for the rural areas. The volunteer's duties also have many similarities to the *Behvarz*. However, they concentrate more on the living conditions of the chronic patients. They effectively become involved in decreasing institutionalization by constant contact with the patients, families and the community.

4.1.4 Training and Research

The following formal training activities are being done in connection with the program:

- Preparation of training manuals for volunteers and general practitioners.
- Attracting general practitioner's interest through holding on the job training courses mainly by using the training material based on ICD10/PHC.
- Training and orientation courses for different levels of urban health personnel particularly disease control and family health technicians. The aim of such training is to make them ready to supervise the volunteers, form files for the cases that are found and prepare reliable statistics.
- Continuing training of volunteers (strictly according to the prepared text), by the technicians and under supervision of district mental health adviser.

The whole program covers four "Healthy City" projects in and around Tehran. In each of these projects a municipal zone collaborates with one university of medical sciences for the implementation of the project. A total of 16 physicians, 21 mental health experts, 11 technicians and 182 volunteers is involved in this stage of the project. GPs go through a three day training given by the psychiatrist in charge of mental health in the concerned university. Another three day training course is designed for technicians. This course is conducted by mental health experts of the university. Finally a twenty session training course is designed for the volunteers and is given by the technicians.

The following studies are being done as the project progresses:

1. Attitude and knowledge test of the community. Two hundred tests and 200 control questionnaires will be filled in each of the four regions, making it a total of 1600 questionnaires.
2. Attitude and knowledge test of volunteers before training program in test and control groups.
3. A prevalence study based on 800 case finding questionnaires. A total of 800 questionnaires will be filled. A 2-day training course is held for the technicians who fill the questionnaire.
4. The number of patients in in-patient facilities whose addresses are from these areas is

determined. This number will be checked periodically to determine the impact of this program.

5. The attitude and knowledge tests of the volunteers and the community will be repeated in 1 and 2 years.

4.1.5 Promotion of mental health and prevention of mental illness

The mental health related activities in Tehran are not only directed towards physical structures, case finding and mental illnesses. There are many community based activities which are in one way or another effective in inducing a better atmosphere for people to live, and thus promote mental health.

The following activities with a positive effect on mental health promotion and the prevention of mental illnesses and addiction have been undertaken in the city of Tehran:

- formation of health committees in the schools in the areas covered by the WHO Healthy City Project. These committees are specifically effective in promotion of healthy life style and the prevention of phenomena like addiction.

- building of many smaller neighbourhood cultural centres in different parts of the city, particularly in deprived areas. These centres provide different groups of the citizens access to many cultural and scientific activities, thus promoting good and positive mental health.

- introduction of vocational training for women, which has proved tremendously effective in giving women from deprived urban communities new opportunities with potentially positive effect on the prevention of depression.

5 DISCUSSION

5.1 National Program of Mental Health

The important feature of Mental Health Program in Iran is the realization of "Integration of Mental Health into Primary Health Care System" on a national scale. The experience of Iran started as one of the pioneer experiments of its kind in The Eastern Mediterranean Region of World Health Organization. However, this program was not by any means the first of its kind. Outside the region, India had started such a program many years ago. Pakistan and Egypt** also started the program earlier than Iran. Why could it become a nationwide program in Iran? In this connection, it is notable that World Health Organization published the landmark publication of "Introduction of a Mental Health Component into Primary Health Care" years after most of these experiences, and it was undoubtedly influenced by them.

The main factor in favor of national level expansion of the Iranian program has been the existence of a very well supported, culturally acceptable Primary Health Care System. The fact that basic human resources *(Behvarzes)* of this system are chosen from the village people is a very important factor. Other reasons may be found in true political will behind the whole health network. Undoubtedly, the existence of a number of mental health professionals willing and ready to challenge the old system with the idea of integration of mental health into primary health care has also played a role. The support and understanding of a considerable part of the psychiatric community have also played an important role. The formal WHO evaluation has shown that the success of this program in Iran is real. The same group have also cautioned about the need to safeguard the sustainability of this program. Continuous supervision, training and research are needed to ensure the realization of such an objective. In order to safeguard the continuation of such a success there is also a need to ensure that all levels get some kind of incentive and compensation for their interest and labour. Continued support from psychiatric community is also necessary.

5.2 Healthy city and Volunteers Project

This is quite a new approach and it is still too early to speak about its success or failure. Need for reform of psychiatric services in greater Tehran has been felt in the last twenty-five years and some steps have been taken in this direction. Undoubtedly, there is still strong resistance that needs to be overcome. The success of integration of mental health into primary health care network was a very important factor in bringing about positive attitudinal changes in decision makers, community and professionals. Mental health started to be seen as a real and applicable part of health, and innovative approaches started to be appreciated and accepted. This program is not going to replace psychiatric services in Tehran, but, if successful, can function as a model for change. It uses a truly community based approach, and can become a basis for a multisectoral model. Through such a model, mental health services in general, and the care of chronic mental patients in particular, can be provided. The "Healthy City" projects provide the organizational framework for integration of many health related activities into the complex fabric of urban life. In such a set up, care of patients become an integral part of a community work that has other programs and horizons. Therefore, a gradual change of attitudes towards mental illness and patients for the better will ensue.

The constraints such program may face come from different sources. As the program is mutisectoral, one area of concern is coordination between sectors involved. The formation of committees with representation from different sectors is an important positive step to avoid conflicts of concerns and interest. Difficulty may also arise from burnt out syndrome among the volunteers. This constitutes a problem for all areas of volunteer work. Refresher courses and different types of supervision, encouragement and moral and material incentives are necessary. The program needs a solid basis for constant evaluation and built-in research on different areas. Only through such an on-going evaluation would it become possible to recommend more widespread application of such an approach.

Finally, it is a reality that vast activities have been undertaken by Tehran municipality during the last eight years. These activities have changed the face of the city. It is now one of the cleanest in

the middle east. The city has been enriched with many new gardens, cultural centres, museums, libraries and the like. To a certain extent, a whole new atmosphere of modernity and progress has prevailed. Such conditions also induce progress in many new areas, including better mental health and improved, decentralized services for the patients. This is a hope shared by many.

*There is a difference of opinion regarding Health House being a separate level or an extension of the Rural Health Centre. The present author sees merits in each argument and therefore prefers to reflect both here.

** At the time of drafting and approval of the National Program of Mental Health, Iran-Iraq war was fiercely being fought and war related issues had highest priority. In a revision of the national program that is scheduled to take place in 1998-99, such emphasis could be placed on provision of care for victims of all stressful conditions and disasters.

REFERENCES

Tarimo, E. Towards a Healthy District, WHO, Geneva, 1991.

Davidian, H., Izadi, S., Nehapetian, V., Motabar, M., A preliminary study of prevalence of psychiatric disorders in the Caspian sea area (Roodsar district) of Iran. Behdaasht e Iran, Vol. 3, No. 4 PP. 145-156. 1971. Farsi (Persian) language.

Shahmohammadi, D., MD, Comprehensive report of the pilot project of "Integration of Mental Health into Primary Health Care System" in *"Shahr i Kurd"* district of *"Chahar Mahal va Bakhtiary"* province. Published by Ministry of Health and Medical Education Tehran, 1990. Farsi (Persian) language.

World Health Organization's Regional Office for the Eastern Mediterranean, Report of the "The Intercountry Meeting on Progress achieved in Mental Health Programs," Isfahan, I.R. Iran. February 1988. WHO-EM/MENT/115-E

World Health Organization's Regional Office for the Eastern Mediterranean, Report of "The Second Intercountry Meeting on Progress achieved in National Mental Health Programs, Nicosia, Cyprus, July 1990. WHO-EM/MENT/116-E

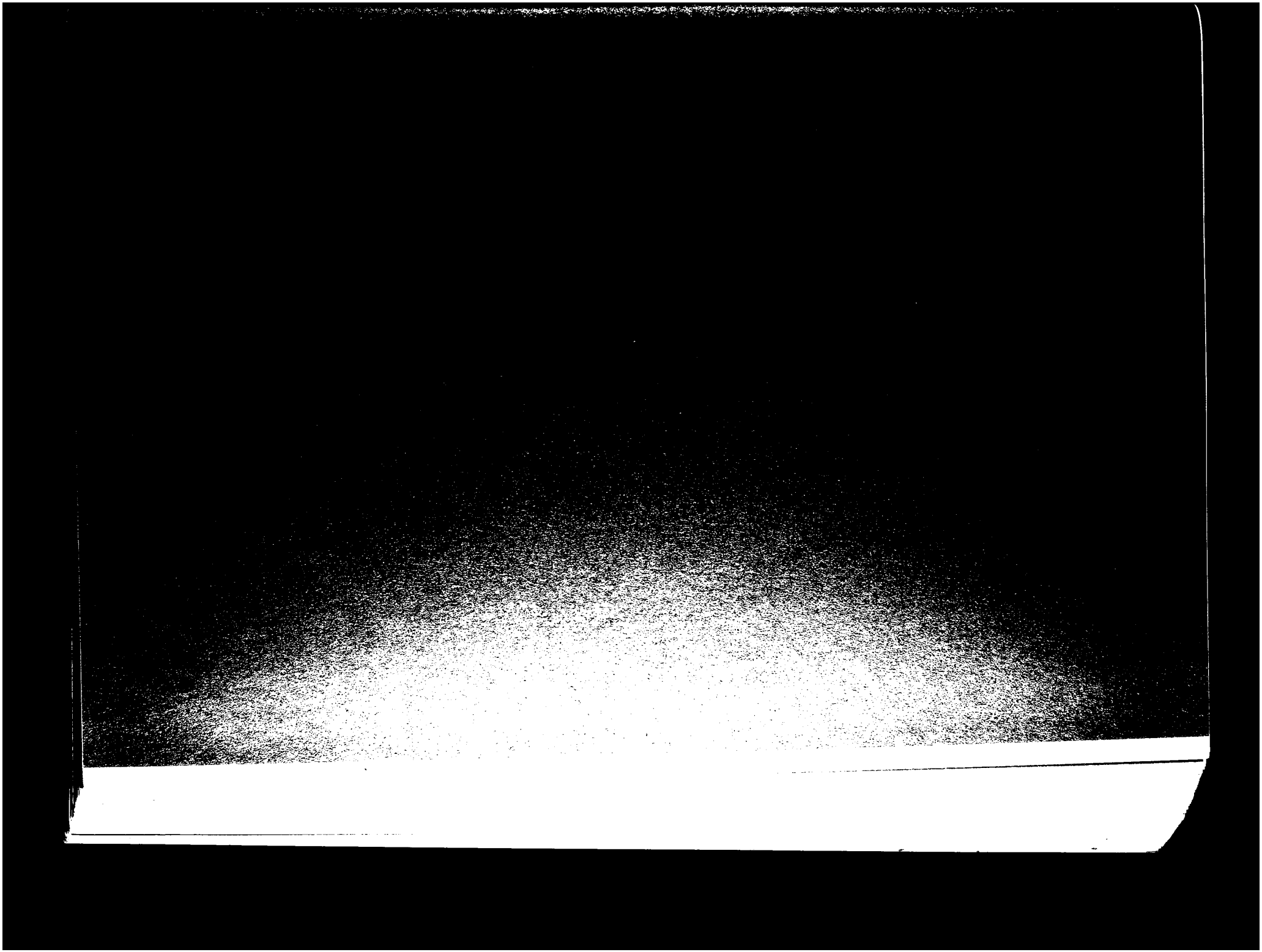
World Health Organization's Office for the Eastern Mediterranean, Report of "The Intercountry Consultation on School Mental Health," Islamabad, Pakistan, November 1993. WHO-EM/MNH/138-E/L

World Health Organization's Regional office for the Eastern Mediterranean, Report of "Intercountry Meeting on The Evaluation of The Progress of National Mental Health Programs in The Eastern Mediterranean Region," Casablanca, Morocco, May 1995. WHO-EM/MNH/142-E/L

N. Sartorius, N.N.Wig, S.R. Murthy, J. Bertolotte, A. Mohit. Independent Evaluation of Iranian Mental Health Program. Non published document of Eastern Mediterranean Regional Office, World Health Organization, 1995.

D. Farajullahi, ed. Healthy City *(Shahr e Salem): A compilation of papers, 1996, Tehran*

Bolhari, Dj. MD. Mohit, A. MD. Integration of Mental health into primary health care system in Hashtgerd (a suburb of Tehran). Final report of a research project, Published by Iran University of Medical Sciences (Tehran Psychiatric Institute). Farsi (Persian) language



CHAPTER 10

COMMUNITY-BASED MENTAL HEALTH CARE IN VERONA, ITALY

Michele Tansella, Francesco Amaddeo, Lorenzo Burti,
Nicola Garzotto & Mirella Ruggeri

(1) Istituto di Psichiatria, Universita' di Verona,
Ospedale Policlinico, 37134 Verona, Italia.

Tel. +39-45-585633
Fax: +39-45-585871
E-mail: tansella@borgoroma.univr.it

CONTENTS

1. THE CITY OF VERONA, ITALY

1.1 Aim of Chapter

The aim of this chapter is to describe the mental health care system of the City of Verona, Italy. This system is largely community-based and was implemented in 1978, according to the provisions of the national reform legislation, approved that year. The principles on which our system is organised will be briefly illustrated and some epidemiologically-based data, collected over the last 18 years using the South-Verona Psychiatric Case Register (PCR), will be presented. The PCR was started to monitor the new system of care provided in South-Verona, one of the three catchment areas in which the City of Verona is geographically divided. Finally the results of some evaluative studies conducted so far in our area will be summarised.

1.2 Verona and Italy

Italy is a country with a population of 56.8 million (67% classified as urban). The most densely populated parts of the country are in the north. There is a north-south split in Italy and those in the prosperous north tend to feel that they work harder and contribute to a higher extent in taxes than those in the south. Italy is rich in important library and art collections. Its economy is the fifth largest in the world and is based on industry in the north and agriculture in the south, with substantial regional differences. Services account for more than half the gross national product.

In 1978 a National Health Service (NHS) providing free health care replaced the existing national insurance system. Life expectancy is 81 years and 74 years for females and males respectively (1995 data). Other information is reported in Table 1.

[illegible]ALITARY

[illegible] the mental health care system of [illegible]
[illegible]-community-based and was implemented in [illegible]
[illegible] reform legislation, approved [illegible]
[illegible]ssed will be briefly illustrated are [illegible]
[illegible] last 15 years using the South Verona [illegible]
[illegible]ed. The PCR was started to monitor [illegible]
[illegible]ree of the three catchment areas [illegible]
[illegible]. Finally the results of some evaluative [illegible]
[illegible]ommunities.

[illegible] and Italy

[illegible] has a population of 56.8 million (1[illegible]
[illegible] parts of the country are in the north. [illegible]
[illegible] inhabitants north tend to feel that they [illegible]
[illegible] more than those in the south. Italy is [illegible]
collections. Its economy is the [illegible]

Table 1

Sociodemographic characteristics of the City of Verona and of Italy.

	City of Verona	Italy
Population*	255,824	56,778,031
Area in Sq. Km.*	199.1	301,302.1
Mean population density*	1285.0	188.0
Age (per 100 total population)*		
under 15 year	12.1	15.8
15-64 years	70.1	68.8
65 years and over	17.8	15.4
Youth dependency ratio (1)*	17.2	23.1
Age dependency ratio (2)*	25.5	22.4
Dependency ratio (3)*	42.7	45.4
People living alone (per 100 total population)*	9.2	7.0
People without permanent address (per 100)**	0.2	N.K.
Birth rate (per 1K)***	8.0	9.21
Mortality rate (per 1K)***	10.4	9.6
Infant mortality rate (per 1K live births/yr)***	4.9	6.6
Mean No. of rooms/resident*	1.8	1.8
Households without bathroom (per 100 households)*	3.6	3.1
Employed population, by economic sector (per 100 all employed)*		
Agriculture	2.0	7.6
Industry	29.1	35.6
Services	68.9	56.7
Employed population, by sex*		
Males	70.9	63.7
Females	41.7	34.0
All	56.0	48.7
Unemployed population, by sex*		
Males	4.8	11.8
Females	4.8	9.7
All	4.8	10.7

(*) Based on the latest national Census, 1991 (ISTAT, 1994; 1995).
(**) Based on an estimate made by the *Comune di Verona (Comune di Verona*, 1996).
(***) Data referring to the City of Verona are taken from the *Annuario Statistico* 1995 (*Comune di Verona*, 1996); those referring to Italy from the Italian Statistical Abstract 1994 (ISTAT, 1996).

(1) Children under 15 years supported by each 100 population of the age group 15-65 years.
(2) Elderly over 65 years supported by each 100 population of the age group 15-65 years.
(3) Dependent persons /children under 15 years and elderly over 65 years) supported by each 100 population of the age group 15-65 years.

Verona is a city of about 260,000 inhabitants, located in Northern Italy, half way between Milan and Venice and on the route from Italy to central Europe via the Brenner Pass. It is predominantly middle class, with services and industry comprising 92.3% of the economic sector. It is a wealthy, University city, which has an airport and is an important rail and marketing centre. It manufactures textiles, machinery, paper, chemicals, processed food, and shoes.

It is pleasant to live in Verona, a beautiful city with many noteworthy architectural landmarks, including a Roman amphitheatre dating from the 1st. century AD (still used for open-air concerts), the Romanesque basilica of San Zeno Maggiore (built mainly in the 12th and 13th centuries), the 14th-century tombs of the Scaliger family, the Gothic Church of Sant'Anastasia, and Castel Vecchio, dating from the mid-14th century. The town is not too large, not too small (has a size which may be called "human") and the people are friendly and open-minded, as well as strongly attached to local traditions. Other data are reported in Table 1. It can be seen that Verona, as compared with the whole country, has a lower birth rate and youth dependency ratio, a lower infant mortality rate, and a lower percentage of unemployed population, both for males and females. The employed population, for both sexes, is higher and more people are employed in services and less in the agriculture and in the industry sectors.

2. HISTORY OF MENTAL HEALTH SERVICES IN ITALY AND IN VERONA

2.1 The 1978 reform that radically changed mental health care

The new mental health Act, law 180, passed in May 1978 by the Italian Parliament, replaced the existing law, which dated back to 1904. The new law was part of the legislation that introduced the National Health Service (NHS). The new law had many innovative aspects that brought about radical change in public policy toward the mentally ill, to fill the gap between the rapid political, social and cultural changes which were occurring from the middle of the 60s in Italy. The practice of psychiatry was taking place almost exclusively in old-fashioned, large and custodial mental hospitals and was subjected to stringent criticism by professionals as well as by lay people and by the media.

The main provisions of the Italian psychiatric reform, which evolved from innovative services that took place in several cities between 1961 and 1978, under the influence of Dr. Franco Basaglia, were the following:

a. It called for a gradual dismantling of all large mental hospitals by blocking new admissions to these institutions after 1978 and all admissions after 1982. Abrupt deinstitutionalisation of chronic inpatients has not occurred and state and private hospitals today continue to care for a consistently decreasing number of these "hospital chronic patients". Complete closure of all mental hospitals is expected in Italy during 1997.

b. As a rule, treatment would be made available to mental patients in their own environment and community services would provide the full range of psychiatric interventions for specified geographical areas;

c. Hospitalisation, both voluntary and compulsory, would take place only in small Units of no more than 15 beds, located in general hospitals and being part of the community-based services;

d. Procedures for involuntary commitment were carefully detailed to safeguard patients' civil rights.

...TALY AND

...health care

2.2 The Italian model of deinstitutionalisation: closing the front door of mental hospitals while implementing "alternative" instead of "additional" community-based services

It has been stated that "the reduction in the numbers of mental hospital beds and admissions should proceed in step with the creation of alternative services, such as Psychiatric Units in general hospitals, day hospitals, outpatient clinics, after-care hostels and rehabilitation workshops" (WHO, 1980).

The success of such a program depends obviously on the budget which is made available and on the amount and quality of human resources and expertise that are put into the project. What is perhaps less obvious is that a key point for reaching the goal of reducing and closing mental hospital beds is the type of organisation of the new system of care, as well as the quality of integration and of co-ordination, at the local and at the country/regional level, of the new community-based services. (Thornicroft & Tansella, in press). They can be either additional (also called complementary), or alternative to the mental hospital. These are actually two different ways of organising community-services. The former model allows back-up by the mental hospital, which survives as a place where the most difficult and refractory cases can still be admitted and stay for a long period of time; the latter explicitly calls for the closure of mental hospitals and for the replacement of the care they provide with that offered by decentralised, residential facilities as well as by other programs, run by the community-based mental health service for all patients, including the most severely ill and most difficult to treat.

It has been postulated that an increase in out-patient and community care by specialist mental health services, made according to the additional (or complementary) model, do not always lead to a reduction in the use of mental hospital beds. (Tansella & Zimmermann-Tansella, 1988). The threshold of tolerance for disturbing patients and behaviours, as well as the criteria for defining a "difficult case to be sent to a mental hospital" may change over time, so the outcome of making more resources available in the community while leaving open the front door of the mental hospital can be an increase

instead a decrease in the number of admissions to those hospitals and/or a shift of the focus of attention of the new services toward a different and much less disturbed category of patients, while the severely mentally ill continue to be treated by the old system of care. Some data seem to confirm this hypothesis (Fryers and Wolff, 1985; Giel, 1986).

In a WHO Working Group on "The Future of Mental Hospitals" it was stated that "there are two ways of replacing mental hospitals by alternative services: the first is to divert patients to the alternative services thus reducing, and eventually stopping admissions to mental hospital altogether. Thus the mental hospital population would slowly decline as long-term residents were discharged or died. The other method would be to close the mental hospital and evacuate or transfer its residents" (WHO, 1978). Italy chose the first way.

2.3 Mental health care in Verona before and after the 1978 reform

As in most Italian cities mental health care in Verona, before 1978, was centred on the mental hospital and located almost exclusively within it. A new mental hospital of 760 beds, the last constructed in Italy, was completed in 1968 on the outskirts of Verona, 15 kilometres from the city centre.

Verona was not involved in the innovative experiences that had been going on since the middle of the 60s in some Italian cities, characterised by a new way of practising psychiatry aimed at reducing the number of mental hospital beds and finally closing the hospitals altogether. The mental hospital in Verona, run in a traditional way, had very few links with the community either in terms of structures or staff. It was not until the new hospital opened in 1968 that the psychiatrists working in the hospital started to provide out-patient care in small Centres, open for a few hours a week, in the Province of Verona. These out-patient services were dealing almost exclusively with the follow-up of patients discharged from the mental hospital and with provision of medication.

Other psychiatric agencies operating before 1978 included two private psychiatric hospitals

(with a total number of 220 beds), some neurological wards in general hospital admitting some patients with minor psychiatric disorders, and one out-patient service for children and adolescents.

In 1970 an Academic Department of Psychiatry was opened, as part of a new School of Medicine. Until 1978 the role of this Department, as of any other University Psychiatric Department in the country, was mainly that of conducting research and providing training to medical and post-graduate students as well as psychiatric care to patients selected according to ill-defined criteria and psychiatric psychological consultations for other Departments of the 1200 bed Academic general hospital. It was not dealing with patients compulsorily admitted (who had to be admitted to the mental hospital), or with long-term chronic patients, or with rehabilitation, day care or home visits.

As the Department developed, out-patient care improved and the principles and the practice of community care became the main topic of interest for most members of the staff. New research projects on social and epidemiological aspects of mental illness started, so after the approval of the new law in 1978 the Department of Psychiatry of the University of Verona was the first academic department in Italy that accepted the proposal of the Regional authorities to provide a comprehensive community-based psychiatric service (CMHS) for the entire adult population of a geographically-defined area, called South-Verona. Some characteristics of this area are reported in Table 2. Four other CMHSs, run by NHS staff, were set up for the remainder of the Province of Verona.

Table 2

Main characteristics of the catchment area of the South-Verona Community-based Mental Health Service (CMHS)

Total population (31 December 1995)	
Southern part of the City of Verona	60,114
Suburban area	14,387
Total area	74,501
Population aged 14 years and over (1995)	65,608
Area in Sq. Km.	75.75

Mean population density	
Southern part of the City of Verona	1,795 /Sq. Km.
Suburban area	340 /Sq. Km.
Total area	983 /Sq. Km

Having agreed to be actively involved in the implementation of the psychiatric reform and in the organisation of a new system of care for South-Verona, the goal of the Department of Psychiatry of the University was to move from mainly custody to care and cure, and to link this shift to changes in research and teaching activities which would support the new trend. A new Psychiatric Case Register (PCR) was set up and the South-Verona CMHS was linked with a Research Unit, funded by the *Ministero della Pubblica Istruzione* (MPI), by the *Consiglio Nazionale delle Ricerche* (CNR) and by the Regional Government, for conducting evaluative research projects.

Undergraduate and postgraduate teaching were reformed to provide psychiatric training which would include working in community settings (Burti & Mosher, 1986). In 1987 the Department was designated by the World Health Organisation as a WHO Collaborating Centre for Research and Training in Mental Health and Service Evaluation.

3. THE SOUTH-VERONA COMMUNITY-BASED MENTAL HEALTH SERVICE (CMHS)

3.1 General organisation

The South-Verona Community-based Mental Health Service (CMHS) was designed to adopt fully the systemic approach; i.e., as a unitary service, in which great emphasis is given to communication between all staff members and to integration between the various clinical activities. It will first described adopting a general framework, and the various facilities and services available to South-Verona residents will then be listed.

[redacted]

All staff members are divided into three multidisciplinary teams, each serving a subsector of the South-Verona catchment area. A fourth smaller team (consisting of three psychiatrists and one psychologist) provides a consultation and liaison service to the other departments of the academic general hospital.

The three main teams are organised according to a "single staff module": with the exception of nurses, all staff (psychiatrists, psychologists, social workers) work both inside and outside hospital and remain responsible for the same patients across different components of the service and through the different phases of treatment. There are hospital nurses (who cover the three round-the-clock shifts in the general hospital ward), hostel nurses, Mental Health Centre nurses and community nurses (who cover two shifts, from 8 a.m. to 8 p.m., and are on call, two at the time, during the weekends and over night). Among nurses, only the community nurses are assigned to one of the three teams.

This module was designed to ensure continuity of care, both longitudinal continuity (through the different phases of treatment) and cross-sectional continuity (through the different components of the service). Within each team each patient is assigned to one particular member of the staff (case manager). Case managers may be doctors, psychologists or senior nurses. Patients seen only at the out-patient department, by a psychiatrist or a psychologist, do not have a case manager.

3.2 Principles of intervention

It is widely accepted that institutionalisation, especially if repeated or prolonged, facilitates and sometimes creates chronicity. One of the main aims of the new service was therefore to prevent or reduce hospitalisation, giving high priority to crisis intervention and long-term community-based care.

The style of intervention is psychosocial: the service aims to provide prompt, adequate and coherent answers to patients' needs, psychological and social as well as practical, while

trying to decrease and control symptoms. Special emphasis is given to integrating different interventions, such as medication, family support, and social work. Case management, patient advocacy, and welfare provision are key aspects of these interventions.

Another aim is to ensure continuity of care, as reported above. One way of pursuing this aim is to promote trusting and stable personal relationships between staff and patients. Special attention is paid to the most disabled and difficult to manage, as well as to chronic patients: apart from the case manager, two or three other staff members are assigned to each patient, so that one is available at any given time, in spite of turnover, shifts and leaves. These patients are regularly assessed and treatment plans are revised accordingly.

Prolonged family complaints about being overburdened and in need of getting away from the patient are not very common, probably because of the strong social role of the family in Italy. When they occur they are taken seriously and worked through.

The evaluation of users' needs is routine in South-Verona, and the commitment to meeting them well established. Over the years, the Service has acquired considerable resources and services to meet such needs. New types of worker have entered the scene: the "*educatore professionale*" (counsellor), the "*operatore di assistenza*" (support care provider), the "*assistente domiciliare*" (housekeeper). In addition, a comprehensive range of treatment and welfare opportunities are available to users with a growing call for co-ordinating interventions and rationalising resources: a natural consequence of the increasing complexity of the system. Thus, a typical problem in dealing with a case nowadays is not one of finding resources or establishing new services, but using the existing ones in a purposeful and co-ordinated way, making the best use of costly staff time.

The mere flow of information on available opportunities may be an issue. Residents rotate, new programs change fast (as in the case of the self-help group, see below), individual workers tend to replicate and stick to interventions proven successful in the past by habit, and so on. Although all important decisions regarding a case are taken within the multiprofessional clinical team after extensive discussion, there is always the risk of making

[redacted]

routine decisions. This may be an unwanted effect of long-term continuity of care of community patients and the smooth functioning of a well-tuned team: two highly desirable situations per se.

The emerging keystone of designing effective and efficient clinical work is matching existing programs and individual needs, i.e. tailoring individual treatment plans by using all the resources already available.

Designing a treatment plan requires both a basic orientation, an attitude in the team, as well as effective "technology". In our opinion, the attitude is the difficult part. A community team is necessarily trained primarily to respond to emergencies. Emergency interventions have the highest priority. Community treatment while reducing the use of the hospital to a minimum, follows close behind. Providing crisis resolution, rather than crisis intervention only, or even being able to prevent emergencies through community-based follow-ups, are ultimate goals (Burti & Tansella, 1995). Thus, a community team necessarily learns to think in terms of emergencies, and emergency interventions.

Planning treatment is a different matter. Putting into practice the design and follow-up of individual treatment plans requires connecting and integrating all the workers involved with a given user. In fact, the advantages of the single staff module may not apply when workers other than those of the clinical team are involved, as happens with severe chronic cases. A way to deal with this situation and to co-ordinate all the different workers is to put together a task group; i.e., calling all workers involved with a case to a conjoint meeting and applying the principles and practice of team meetings (e.g. from setting goals to assigning tasks and performing follow-up evaluations together) to this ad hoc task group. This also turns out to be an effective training opportunity in rehabilitation, both for the relatively unskilled workers like the housekeepers, and for the skilled, but more emergency, and medically, oriented team members.

3.3 Residential care in the community for long-term patients

Since the front door of the mental hospital was partially closed from 1978 and completely closed from 1982 an important aspect of our community-based service has been the provision of residential care for long-term patients.

Two residential facilities are available in South-Verona, as part of the CMHS. One is a 24-hour-staffed supervised hostel, opened in 1990, with six places for users in need of continuous supervision. It consists of two apartments in a block: a large one for the hostel proper, and a small adjoining one, used as a base by the staff. The other, a group home, also located in a normal block, provides 6-hour staff supervision on working days, and offers four places.

Each facility is co-ordinated by an "*educatore*" (counsellor), assisted by two "*operatori di assistenza*" (support care provider) per shift. Community nurses visit daily to administer medication and are on call overnight and on weekends for medical and psychiatric emergencies. The psychiatrist in charge of the Mental Health Centre ensures medical supervision, assisted by a resident physician. Goals of the program in both facilities are to provide accommodation, care, supervision and rehabilitation in daily living and social skills to the residents. In fact, while they are re-assured they may remain indefinitely if they want to, they are also involved in activities to develop those daily living skills and social capabilities that are relevant for more independent living.

Residents graduating from the supervised hostel may move to the group home, while those of the group home may move on to independent living. Alternatively, in order to prevent dislocation, a plan is under discussion of gradually withdrawing staff supervision and assigning the flat of the group home to the residents themselves, who will eventually assume full responsibility for it. Staff will visit occasionally, while nurses will be on call overnight and during weekends. In effect, the group home will be converted into supervised housing. Instead of displacing residents, the service will move out to start another group home elsewhere.

All residents are engaged in household tasks and some of them participate in rehabilitation or vocational activities outside the house during the day. A self-care group teaches personal hygiene and grooming, while a weekly joint meeting (staff and residents) provides the opportunity for discussing interpersonal issues and making group decisions for everyday life and recreational activities. The staff of the supervised hostel organise social and recreational activities over weekends and invite the residents of the group home to join. Summer, and occasionally winter vacations are usually very successful and very much appreciated by the residents.

More recently two interesting additional services have expanded the role of these facilities. The service module of the hostel now houses a patient in need of next door supervision, and plans are being made to graduate a hostel resident so that he may join him. The group home accepts day patients, i.e. users living independently, who may benefit from participating in group rehabilitation activities. This day care service has proven very successful, probably because of the stability and harmony of the residential group.

Both facilities are funded by the ULSS (the local health authority) and residents are not required to contribute in any way, except for recreational activities and vacations. The ULSS also funds an individual apartment assigned to a long-term patient of the Service before the two residential facilities even existed, more than ten years ago. She has successfully lived there ever since.

A typical candidate for the residential facilities is a long-term community patient who has also accumulated long, or "revolving-door", stays in the hospital ward, does not have a family, or whose relationship with the family has completely deteriorated. When a place becomes available, the community team considering the new candidate, and the staff of the residential facility, discuss the case jointly. An emphasis is given to specifying realistic rehabilitation goals to prepare the resident for future alternative accommodation once independent living skills are acquired. Once admitted, the new resident remains in the care of one of the three main multidisciplinary teams (see section 3.1), which continues to be responsible for the overall treatment plan.

While all existing places are usually occupied and the need for more is voiced from time to time, the service aims to use this kind of facility sparingly (14 places in total, corresponding to a rate of about 20 per 100.000 at risk), and in preference to promote the preservation of independent living arrangements through community care and rehabilitation.

3.4 Communication within the CMHS and links with other health and social services

To ensure good communication and co-ordination between all staff members, a series of meetings take place: each day starts with a half hour general meeting at the Mental Health Centre. The doctor who has been on call for the previous day briefly reports on patients seen at the casualty department, and gives relevant information on all other patients who were referred to the service. The head nurses of the psychiatric ward in the hospital and of the Mental Health Centre, one representative member of the staff from the hostel, and eventually other attendees briefly report on information that they believe should be known by all other staff members. After the general meeting each multidisciplinary team meets to organise clinical activities for the day, to be carried out in the various facilities of the service, including the hospital ward as well as community services. There are also weekly meetings on the hospital ward, at the Mental Health Centre, at the hostel and meetings to discuss special cases.

The South-Verona CMHS is well integrated between ward and community, and allows patients easy access to most of its components and easy transfer from one component to another, according to needs. A "drop in" approach is encouraged at the Mental Health Centre and patients can seek care from specialist services directly, without previously attending GPs. However most patients are referred by GPs and referred back to them by the CMHS, when it is felt that less stigmatising care can be provided in primary care (Balestrieri et al.,1994). There are good relations between primary and secondary care and meetings are held at regular intervals with GPs most interested to discuss how to improve the interface between primary care and mental health services.

[redacted]

Our CMHS does not include services to schools, and liaison with police is only occasional.

3.5 Components of the CMHS

The Community Mental Health Centre is the linchpin of the CMHS and is where staff meetings take place and interventions are planned and initiated. The Centre, located in an old two storey house with a garden, not far away from the Academic general hospital, is open on weekday from 8 a.m. to 8 p.m. and on Saturday from 8 a.m. to 5 p.m. Therapeutic programs include crisis intervention, day care for acute and chronic patients and social skills groups. The Centre also serves as an informal meeting place for "users", and it is conceived as a flexible tool whose organisation can be modified from time to time to meet the user's changing needs (see Fig. 1 and 2).

The psychiatric ward is an open ward of 16 beds located in the Academic general hospital which has about 1,000 beds. It is a traditional hospital ward, similar to all other medical wards in the hospital and its door is locked when there are patients who have been compulsory admitted (see Fig. 3).

The outpatient department provides psychiatric consultations and individual and family therapy. Offices are located in the general hospital and in the Mental Health Centre.

The consultation liaison service for other medical and surgical departments maintains psychiatric integration with other hospital-based medical activities and ensures continuing contact with our patients when hospitalised for medical reasons.

The emergency service: There is a psychiatric emergency room service at the general hospital, open 24 hours a day, seven days a week. It is run by a psychiatrist from our team, who is on call. To ensure therapeutic continuity, the doctor is usually assisted during working hours by the treatment team members who are (or will be) in charge of the patient requiring the urgent intervention. There is also an emergency night and week-end service, run by two psychiatric nurses from our team, who are on call and may provide care in our flats and in our hostel, as well as at our patients' homes, co-ordinated by the psychiatrist on call.

Home visits can be made to provide crisis intervention in response to emergency calls, but for chronic patients these are usually planned in advance and offer regular, long-term support and care to patients and their families with the goal of minimising relapses and hospital admissions. Home visits are highly regarded by the service and are well accepted by patients and families.

[redacted]

One group home and two apartments, offering different levels of supervision, and one hostel (with 8 beds, supervised 24 hours a day by support workers and counsellors and occasionally visited by nurses), are also available (see Fig. 4).

A general description of our system of care was provided using the International Classification of Mental Health Care (WHO-ICMHC; Amaddeo et al, 1995a). This instrument was developed under the auspices of WHO, to classify the curative activities of mental health services and to be applied in different countries. When applying the ICMHC the mental health system of care is firstly divided into its component parts (for example general hospital ward, outpatient clinics, domiciliary visits, and so on). Each component is then rated, using a 4-point scale, on the intensity of care for eight dimensions of care (for instance problem assessment, crisis management, or psychopharmacological interventions). The ratings were made by a senior psychiatrist from our CMHS very familiar with all components of the service. The definitions of all dimensions used are reported in Table 3 and can be summarised as follows: very intensive crisis management is provided not only in the hospital ward but also in the liaison and emergency room in general hospitals and, to a lesser degree, in day care services and on home visits; very intensive supportive social interventions are provided in the general hospital ward, day care services, the outpatient service at the Mental Health Centre and on home visits. Support for activities of daily living are intensively provided at the sheltered apartments. Out-patient care in primary care was not rated since it is a recent development of our service, which involves only one of the three multidisciplinary teams.

One group home and two grou

hostel (with 8 beds, supervised

occasionally visited by nurses

A general descr

Classification of

instrument was

mental health ser

the mental health

general hospital

then rated, using

instance problem

The ratings were

components of the

and can be summarised

the hospital ward

lesser degree, in day

interventions are provided

service at the Mental Health

are intensively provided at the

not rated since it is a recent

three multidisciplinary teams.

Table 3

Activities of the South Verona Community-based Mental Health Service (CMHS), described using the international Classification of Mental Health Care (WHO-ICMHC 1st Ed.)

	Dimensions							
Modules of Care	**PROB**	**CRIS**	**SOCI**	**PSYC**	**BIOL**	**MEDI**	**ADLF**	**ACCO**
General Hospital Ward	2	3	3	1	3	3	2	2
Consultation liaison in General Hospital and emergency room	2	3	1	0	1	0	0	0
Day Care	1	2	3	1	2	2	1	1
Out-patient care in the Mental Health Centre	1	1	3	1	2	1	0	0
Out-patient care in General Hospital out-patient dept.	2	1	1	2	2	0	0	0
Out-patient care in primary care	-	-	-	-	-	-	-	-
Home visits	1	2	3	1	1	0	1	0
Sheltered apartments	0	0	2	0	2	1	3	3

Dimensions:

PROB= problem assessment
CRIS= crisis management

SOCI= attendant and supportive (social) interventions

PSYC= psychological interventions
BIOL= biological-psychiatric interventions

MEDI= activities related to general medical care
ADLF= the taking over of tasks concerning activities of daily living/functions (self-management)
ACCO= possibilities of residence and accommodation within the framework of mental health care

Categories

3 = intensive activities
2 = moderately intensive activities
1 = minimally intensive activities
0 = no or only very incidentally occurring activities

Definitions of dimensions used to describe the services in South-Verona by the WHO International Classification of Mental Health Care (WHO-ICMHC)

Dimension	Definition
PROB	Problem assessment (diagnostics) this dimension concerns all the activities in connection with the (often but not always initial) organisation of care being provided
CRIS	Crisis management all those activities aimed at bringing crisis situations under control at short notice, by which interventions may be directed at psychological, social as well as somatic problems
SOCI	Attendant and supportive (social) interventionsall interventions, directly or indirectly focused on aspects of or person in the social environment within which the patient must function, including the concrete ways in which he or she deals with the environment
PSYC	Psychological interventions These individual or group interventions will primarily be focused on facilitating changes in the patients. In general, techniques based on theoretical models will be applied, which require specialisation (e.g., all forms of psychotherapy, psychomotor therapy and creative therapy)
BIOL	Biological-psychiatric interventions (prescription and control of psychopharmacological medication and other techniques)all activities (including all measures due to somatic and/or psychological complications) pertaining to the application and actual control of biological-psychiatric techniques
MEDI	Activities related to general medical care all activities (including medical nursing) directed towards the general medical care of psychiatric patients to the extent that these activities are carried out within the framework of mental health care provided by the module of care in question
ADLF	The taking over of tasks concerning activities of daily living or functions (self-management): all those activities that are equivalent to the partial or total taking over by staff members of the module of care of such tasks as would normally be carried out by people themselves, the types of tasks involved in this category having to do with managing for themselves
ACCO	Possibilities for residence and accommodation within the framework of mental health care: all activities pertaining to providing a permanent or temporary accommodation within the module of care

3.6 Staff

The South-Verona Community-based Mental Health Service (CMHS)'s permanent staff include 11 psychiatrists, 5 psychologists, 2 social workers, 3 health visitors, 13 community nurses, 14 ward nurses and 2 counsellors. There are also a number of psychiatrists and

[redacted]

psychologists in training, as well as *operatori di assistenza* (support workers) on contract. However, psychiatrists and psychologists, as well as other staff members, are involved not only in care of the patients, but also in research and teaching (for both undergraduate and post-graduate students and Ph.D. students).

In order to make comparisons with other services the average number of sessions (of approx. 4 hours) per week dedicated to clinical work has been estimated and corrected to that for a standard population of 100,000 adults (see Table 4).

Table 4

South-Verona Community Mental Health Service (CMHS) and Institute of Psychiatry of Verona

Number of staff and sessions (4 hours) of staff time per week dedicated to clinical work

	N. of Staff	Sessions/week Average N.	Rate /100Kadult pop.
Professors of Psychiatry	6	16	24.4
Psychiatrists	5	36	54.9
Trainee Psychiatrists	20	120	183.1
TOTAL	31	172	262.5
Profs. of Medical Psychology	1	3	4.6
Psychologists	4	26	39.7
Trainee Psychologists	4	24	36.6
TOTAL	9	53	80.9
Social workers	2	16	24.4
Health visitors	3	12	18.3
Community nurses	13	117	178.6
Ward nurses	14	126	192.4
Operatori di assistenza (Hostel basic care providers)	10	90	137.4
Educatori professionali (Hostel counsellors)	2	18	27.5

[redacted]

3.7 Distinctive features of the mental health service in South-Verona

In conclusion, the main features of the South-Verona mental health service that could be considered "distinctive" to the service are as follows:

a. It is not experimental; we were set up as a result of legal changes based on a National Act flexible enough to permit development of a system of care which is suited to local needs, and we have been running our services for 19 years.

b. It was designed and is still functioning as an alternative to the old hospital-based system of care, rather than being complementary to it. The front door of the mental hospital has been closed to new admissions since May 1978 and to all admission since January 1982 (Tansella, 1991);

c. The clinical model developed in South-Verona is "systemic" and is a "single-staff module": all staff apart from nurses work both inside and outside hospital and remain responsible for the care of the same patients across different components of the service and through the different phases of care. The "single staff" module is designed to ensure continuity of care and to encourage full responsibility and commitment by the service.

d. The South-Verona CMHS is well integrated, and allows easy and informal access to patients. It is a public service run by the National Health Service. Payment is not required, except for a fee for out-patient visits (this applies only to wealthy patients and for those who are not considered long-term).

e. Every effort is made to meet user's needs with individual care plans. A well established clinical practice in South-Verona is one of critically examining the user's explicit request in order to recognise what his/her real needs are, as extensively described elsewhere (Burti et al., 1986; Mosher & Burti, 1989). This process implies questioning who originated the request for intervention (the real, often disguised or secret customer), besides the usual assessment of psychosocial, precipitating and intervening factors.

f. The evaluative research has included, since 1994, parallel evaluations of needs costs and outcome, as a way of monitoring and evaluating change. Epidemiological data have been collected, in the same year (1992), on all five levels of the Goldberg and Huxley model (general population, general practice total morbidity, general practice conspicuous morbidity, all psychiatric services, psychiatric hospitals and wards) (Tansella & Williams, 1989);

4. OTHER PSYCHIATRIC SERVICES AVAILABLE TO SOUTH-VERONA RESIDENTS

Other psychiatric services within the larger province of Verona are available to South-Verona residents, as well as to residents of several other catchment areas. These include two private psychiatric hospitals (220 total beds), where patients from a larger area in north-east Italy can be admitted at the expense of the National Health Services, the Mental Hospital of Verona (with 160 beds for old long-stay patients from the whole Province of Verona, admitted before 1982; on December 1995, 11 patients were from South-Verona and this is a very stable, low need group, who has any contact with our community-based service) and a private semi-residential facility for the rehabilitation of patients with learning disabilities, run by a charitable organisation.

Verona is served by a number of psychiatrists and psychologists in private practice (who have only occasional links with public services and are mainly involved in the treatment of minor psychiatric disorders), by a Centre for Substance Abuse (which has a larger catchment area and again only few links with our Service) and by an out-patient psychiatric service for children and adolescents.

5. USER'S ORGANISATION

A self-help group was initiated in 1990 by a psychiatrist in training from the South-Verona Psychiatric Service and a few young mental health users. They shared an interest in practising sports, especially jogging. The junior doctor already had experience with self-help groups for alcoholics, and transferred the model to mental health users. Other social activities were practised besides sports, including those common in other user organisations, like consciousness raising and advocacy. The group steadily grew to the present number of about 400 people in contact, including members from two more groups established in nearby areas. In 1995 the group formed an association, "*I Cavalieri di San Giacomo*". *San Giacomo* was the name of the old mental hospital in Verona. The area still keeps the name and presently includes the university hospital, the South-Verona Mental

Health Centre, and a park, so the name is full of associations.

The User's Organisation has been regularly supported by the South-Verona CMHS: the funds of a pilot project provide a part-time job for the psychiatrist who founded the group and a full-time job for an "*educatore*"; the psychiatrists from the Mental Health Centre and a social worker from the service also allocate part of their working time to the Organisation. In addition, the Organisation uses the Mental Health Centre as a temporary base, so the community nurses of the centre are constantly involved with the members of the Organisation. This co-operation has proven mutually enriching to date. The population attending the Mental Health Centre has grown in number and become much more heterogeneous: younger and more active people are around at any given time, making the place a lively one. Tenuous but persistent institutional barriers and taboos that had survived for more than a decade, i.e. restrictions in the use of spaces (like the kitchen) or appliances (like the computer) quickly disappeared. Nurses have been active in volunteering to organise shows, parties and other events with the users.

The goals of the group are those typical of self-help organisations: participation is totally voluntary, the approach is non medical and involves reciprocal support, self-determination, counselling, education and advocacy. However, while other self-help groups have developed services completely outside the mental health system, this organisation operates within the system and in close collaboration with it. Three more goals are highly valued by the organisation and actively pursued through various activities: finding work and supporting those with jobs, housing, and education.

Activities are many and various and take place every day of the week, especially in the evening and over weekends, when statutory services and other day care services are generally closed. They include:

- **Organisational activities:** a well attended, weekly plenary session takes place on Thursdays. Besides dealing with issues of general interest, each individual situation is reviewed with regard to housing, work, health and other basic needs. This conveys the feeling that each member really counts as a person. A bulletin is published weekly, containing the schedule of activities, organisational information, individual needs, and various cultural sessions. The format is quasi-professional. The executive

board of the Organisation also meets weekly, as well as various sub-committees. Contacts with other associations are highly regarded and visits are exchanged when feasible

- **Job support**: contacting job centres and employers is everyday routine, as well as supporting members to find, enter and maintain employment. An ironing group and a cleaning group provide vocational rehabilitation and small job opportunities to members. During the fiscal year 1996, 103 members have found a job thanks to the Organisation (29 in temporary jobs, 15 in worker co-operatives; the rest in regular jobs of unlimited duration: tenure and success varied, but only those completing the trial term are counted)

- **Reciprocal supported accommodation**: members of the Organisation give temporary hospitality to other members in need of shelter for various reasons. The guest shares the expenses, but a subsidy provided by the ULSS may be used as well, to support the initiative

- **Vocational training**: members participate in computer classes, driving courses, seminar on employment law, etc.

- **Culture and recreational activities**: includes participating in civic committees, going to the library, the movies, the theatre and concerts. Practising sports is still an important feature.

During 1996 about 250 members have actually participated in one or more of the activities described above.

The self-help organisation has proven effective in both reducing personal and social discomfort and related stress, thus probably preventing the occurrence of some psychiatric episodes. By providing an alternative to professional care through reciprocal support, it has probably reduced the risk of institutionalisation. It has been far more effective than official bodies in helping users to find and maintain a job. As a consequence an agreement for co-operation has recently been signed by the agency of the ULSS responsible for the work settlement of people with learning disabilities and the Users' Organisation. Reciprocal, supported accommodation is also of interest, and may eventually result in permanent group homes, which will be a more normal alternative than the sheltered facilities of the service.

In the near future, a worker co-operative will start as a new pilot project implemented jointly by the service and the Users' Organisation. This will both offer some work slots,

[redacted]

and inaugurate a completely new experience in South-Verona: a users' managed business.

6. FROM SERVICE MONITORING TO SERVICE EVALUATION

6.1 The South-Verona Psychiatric Case Register (PCR)

The South-Verona Psychiatric Case Register (PCR) started on 31st December 1978 with a prevalence count and has been operating ever since. At first contact with the psychiatric service, socio-demographic information, past psychiatric and medical history, and clinical data are routinely collected for people aged 14 years and over. These data may be updated at successive contacts if necessary.

Admissions to psychiatric wards, private clinics and neurological wards (with a psychiatric diagnosis) are recorded. Also the number of days spent in hostels run by the South-Verona CMHS are recorded. All mental health services providing care to South-Verona residents, including private institutions, the out-patient service for substance misuses and the mental health service for children and adolescents, mentioned in Section 4, report to the register information regarding patients over 14 years of age. Psychiatrists and psychologists in private practice and general practitioners (GPs) do not report to the register. The private facility for the rehabilitation of those with learning disabilities, and geriatric hospitals and other services for elderly are not considered psychiatric institutions, and do not report to the Register.

Outpatient contacts (all other contacts but admissions to hospital, hostels and wards) with psychiatrists, psychologists, social workers and psychiatric nurses are recorded. Telephone calls which are considered important from a clinical point of view and that are annotated in the clinical records are also recorded in the PCR. Each attendance at an out-patient clinic and each domiciliary visit is counted as a contact. The same applies to day care at day hospital and centre, where each daily attendance is counted as one contact.

Within the South-Verona CMHS only, each out-patient, daypatient or domiciliary contact is

[redacted]

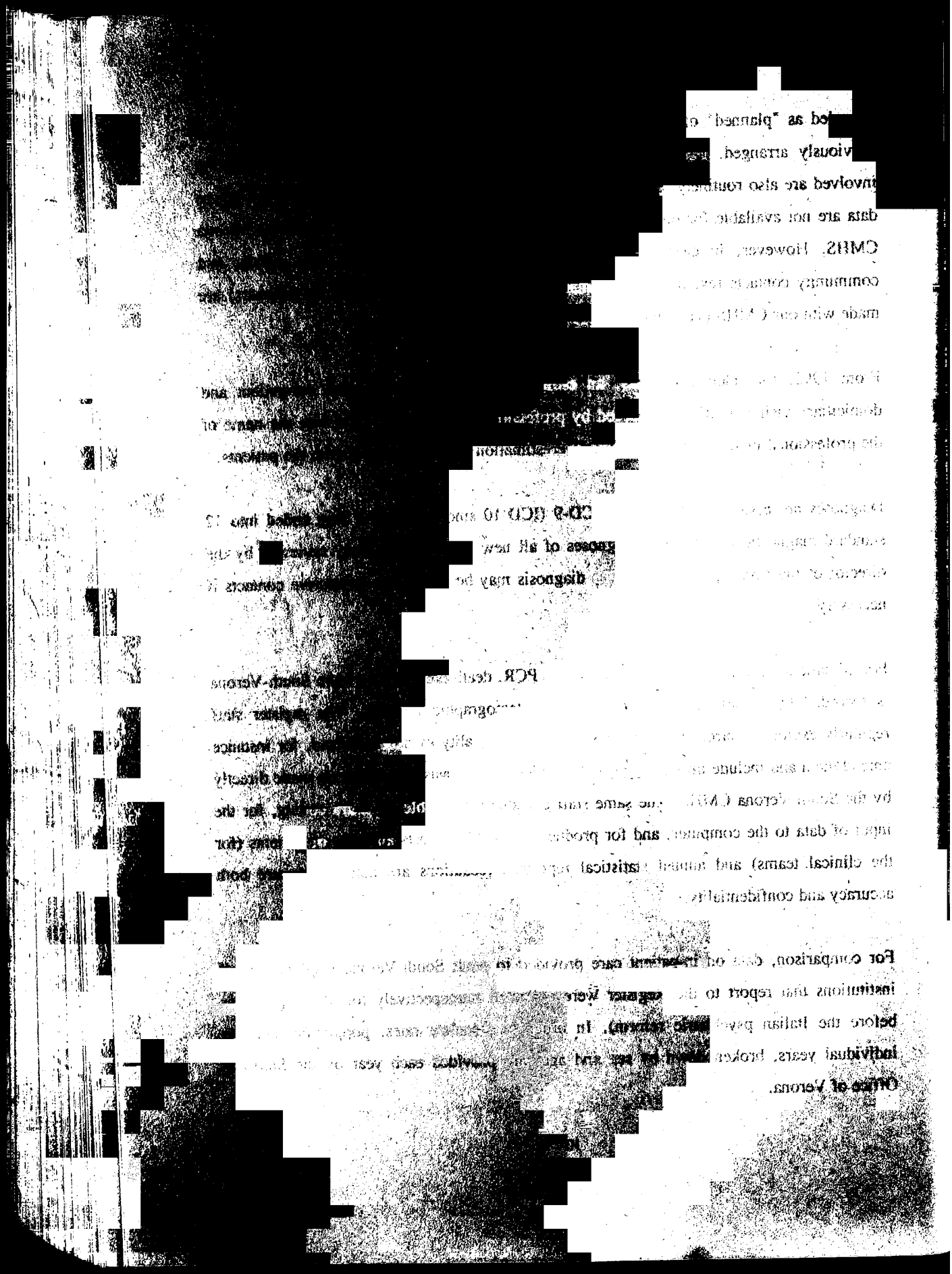
recorded as "planned" or "unplanned", according to whether or not an appointment was previously arranged. For these contacts the source of referral and the professional(s) involved are also routinely recorded, by the same professional who saw the patient. These data are not available for outpatient contacts with other services outside the South-Verona CMHS. However, in each year, more than 95% of all outpatient, day patient and community contacts (excluding the contacts made with the service for drug misusers) are made with our CMHS (Tansella et al., 1979-1995).

From 1992, for calculating costs, an estimate of time spent for each out-patient and domiciliary visit is routinely recorded by professionals but is not linked with the name of the professional involved, thus avoiding overestimation of the time spent with the patients.

Diagnoses are assigned according to ICD-9 (ICD-10 since 1992) and then coded into 12 standard diagnostic groups. The diagnoses of all new cases are routinely reviewed by the director of the case register (MT). The diagnosis may be updated at successive contacts if necessary.

For all patients who have been entered into the PCR, death or migration from South-Verona is recorded by means of annual checks with demographic registers. The register staff regularly exercise control over the completeness and quality of data collected, for instance amend them and include missing data, with particular emphasis on the coding made directly by the South-Verona CMHS. The same staff are also responsible for extra coding, for the input of data to the computer, and for producing monthly reports and lists of patients (for the clinical teams) and annual statistical reports. Precautions are taken to ensure both accuracy and confidentiality.

For comparison, data on in-patient care provided to adult South-Verona residents by all institutions that report to the Register were collected retrospectively for 1977 (one year before the Italian psychiatric reform). In order to calculate rates, population data for individual years, broken down by sex and age, are provided each year by the Statistics Office of Verona.



6.2 Clinical, administrative and research uses of the PCR

The South-Verona PCR is used for clinical, administrative, and research purposes. The clinical uses include:

- The provision to the clinical teams of lists of severely mentally ill patients who have been in contact and are to be reassessed at regular intervals to ensure better continuity of care and improved practices. Working definitions of severely mentally ill can be reached pragmatically and are suggested to the register staff by the clinicians. For this purpose a combination of several variables, such as diagnosis; number of hospital admissions, number of episodes of illness, total number of contacts over a given period, occupational status, multiple agency use, and so on can be used.

- The provision to the clinicians, on request, of a complete description of admissions and contacts of individual patients over a specified period of time.

Administrative uses of the register include:

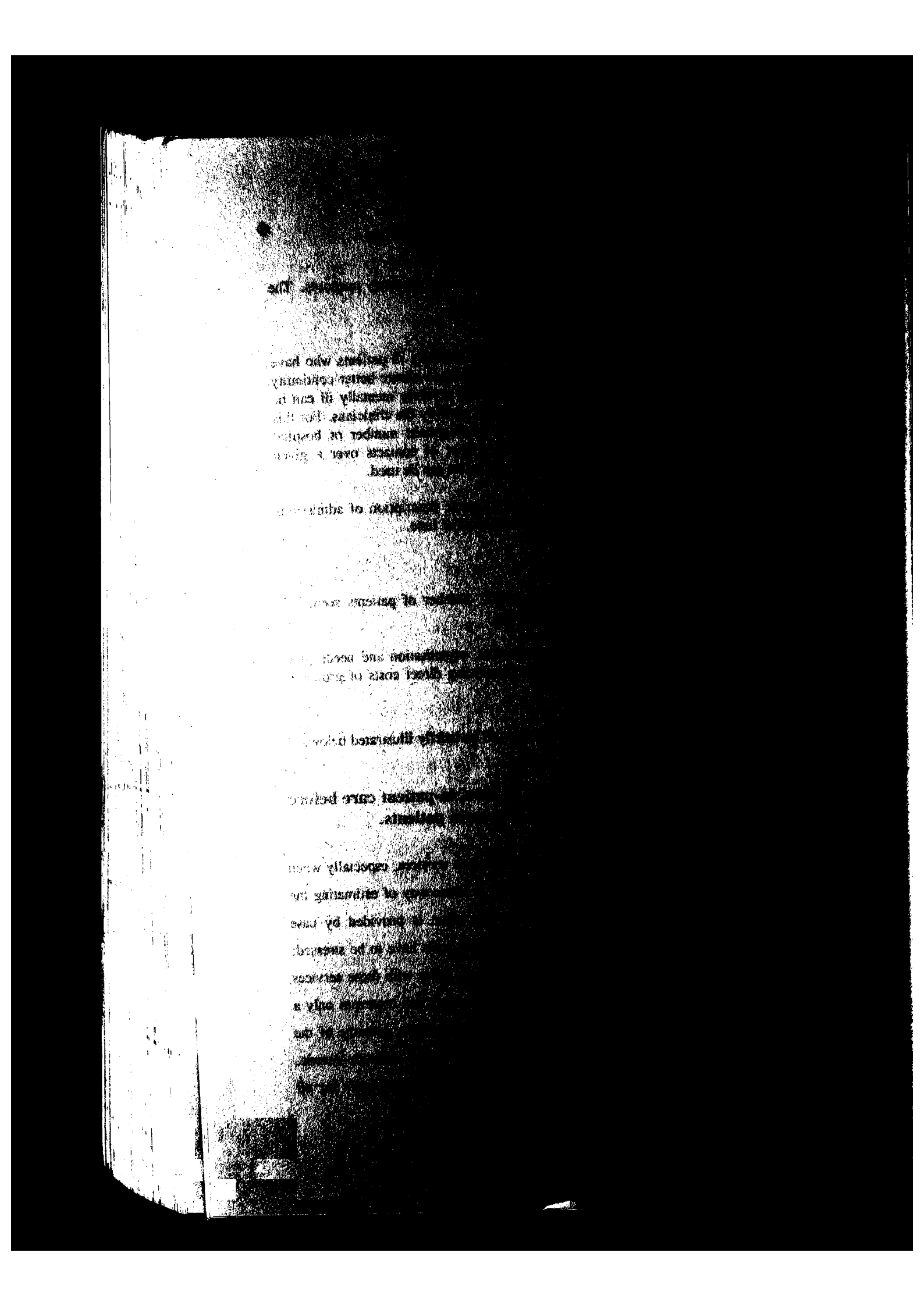
- The provision of prevalence figures, incidence rates, number of patients seen, and number of visits made over different periods of time

- The monitoring of the effects of changes in resources, organisation and needs, over time, and the use of the register as a basis for calculating direct costs of groups of patients (Amaddeo et. al, in press).

The use of the South-Verona PCR for research purposes will be briefly illustrated below.

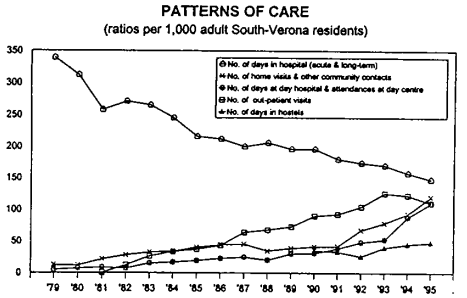
6.3 Longitudinal description of patterns of care, in-patient care before and after the reform, long-stay and long-term patients.

Monitoring is a useful first step in the evaluation of mental health services, especially when carried out for a sufficiently long period of time. The most accurate way of estimating the uptake of psychiatric care by a geographically defined population is provided by case registers. On the other hand the main limitation of these research tools have to be stressed: figures derived from registers obviously can only reflect contacts made with those services which provide information to the register (usually specialist services) and represent only a crude attempt to infer, from the changing patterns of care over time, the outcome of the care provided. This assumption, by the way, can be made only when, as in South-Verona, migration out of the area and deaths are routinely recorded by the case registers for all



patients who have been entered into it, making it possible to establish whether someone who ceases contact with psychiatric services has left the area, died, or stopped attending for other reasons (Amaddeo et al., 1997b).

Longitudinal monitoring of service utilisation in South-Verona showed that, from 1979 to 1995, hospital care (acute and long term, provided by both public and private institutions) consistently decreased whereas outpatient care, home visits and other community contacts, number of days and attendance at day hospital and centres and number of days in the hostel run by the South-Verona CMHS steadily increased (see Fig. 5).



The decrease in the use of beds was mainly due to the decrease of long-stay patients in the mental hospital and happened while psychiatric beds for short and medium term stay were available (220 beds in private hospitals, where patients, according to an agreement with the regional health authority, can be admitted at the expense of the National Health Service). Comparison of inpatient admissions before and after the 1978 psychiatric reform showed that in 1995 (17 years after the reform), as compared with 1977 (one year before), there was a 24% decrease of inpatient admissions, with a 94% decrease of compulsory admissions (which never exceed 22 admissions per 100,000 adult population) and a complete halt of admissions to state mental hospitals (Tab. 5). As a consequence the mean number of occupied beds per day consistently decreased over time and in 1995 was 62% lower than in 1977. This decrease is entirely due to the reduced number of patients remaining in the state mental hospital.

In 1995 the total number of beds occupied in both public and private hospitals was 40 per 100,000 adult South-Verona residents. If we exclude the state mental hospital the rate is 23 per 100,000 at risk and this latter figure has been constant for some years (Tab. 6).

patients who have been entered
ceases contact with psychiatric
other reasons (Amaddeo et al.,

Compliance) monitoring or

per 100,000 at risk and this

100,000 adult South-

In 1995 the total num

returning to the ser

lower than in

marked

patients

a

the mean

was 62%

Table 5

In-patient admissions before (1977) and after the Psychiatric Reform

(ratios per 100,000 adult south-Verona residents)

	1977	'79	'81	'83	'85	'87	'89	'91	'93	'95	Difference
											'95 vs. '77
Compulsory	55	8	10	18	8	22	22	11	11	3	**-94%**
To state mental hospitals (volunt.)	194	86	8	0	0	0	0	0	0	0	**-100%**
To other facilities:											
Public care	172	304	188	391	302	336	273	263	313	273	**+59%**
Private care	67	72	70	97	80	64	78	48	85	95	**+43%**
TOTAL	**488**	**469**	**277**	**507**	**390**	**422**	**373**	**321**	**509**	**371**	**-24%**

Table 6

Mean occupied beds/day before (1977) and after the Psychiatric Reform
(ratios per 100,000 adult south-Verona residents)

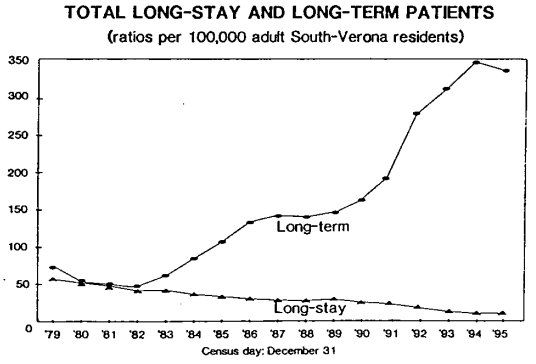
	1977	'79	'81	'83	'85	'87	'89	'91	'93	'95	Difference
											'95 vs. '77
In state mental hospitals	86	69	50	40	32	29	29	25	19	17	**-80%**
In other public hospitals	9	16	12	17	17	16	15	16	15	16	**+78%**
In private hospitals	9	7	8	11	7	7	9	7	11	7	**-22%**
TOTAL	**104**	**93**	**71**	**68**	**57**	**52**	**53**	**48**	**46**	**40**	**-62%**

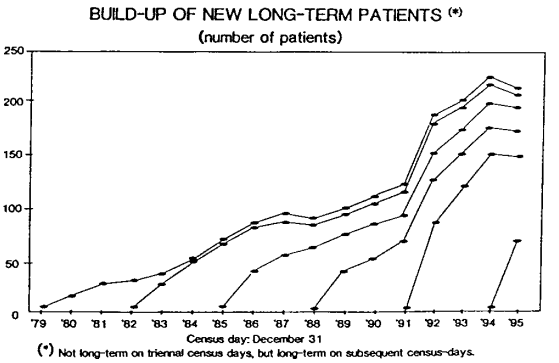
We used the PCR to monitor chronic use of services over the years. Since, as a consequence of the Italian reform, admissions to mental hospitals have been halted and these are the main hospitals where patients admitted can became long-stay, we studied

[redacted]

chronic use of services calculating rates of two groups of chronic patients: long-stay and long-term (who were not long-stay). Long-stay are defined as "those who stay in one or more hospitals continuously for one year or more". We defined as long-term "those not-long stay patients who were continuously in contact, for one year or more, with some psychiatric service (including psychiatric hospitals and wards), not necessarily the same service or only one service, with a period between two contacts never longer than 90 days". Contacts here include a day in a psychiatric ward or in a day hospital or centre and all contacts with outpatient and domiciliary services.

Since 1979 the numbers of long stay patients have been consistently decreasing, whereas the numbers of long-term patients steadily increased up to 1994, and for the first time showed a decrease in 1995 (Fig. 6). If we plot on a graph, every three years, new long-term patients, i.e. "those who were not long-term (or in continuous care for one year or more) on triennial census days, but were long-term on subsequent annual census days" we can see that the first five cohorts showed a consistent accumulation of patients up to 1994 and that the sixth cohort, i.e. those patients who were not long-term in 1994, has already started to accumulate at a similar rate to previous cohorts. (Fig. 7).



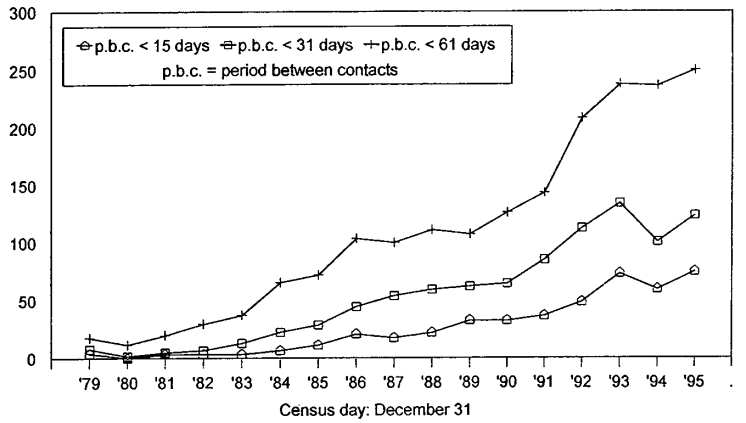


If we use alternative definitions of long-term patients, i.e. "those with periods between two contacts never longer than 60 days, or 30 or 15 days", we can see that all these categories of frequent users of mental health services are accumulating over the years (Fig. 8). On the

1995 census day there were 164, 81 and 49 South-Verona patients who were in continuous care for one year or more, having a contact at least every two months or one month or two weeks respectively.

The South-Verona CMHS is now taking care of most psychiatric patients who, before the reform, would have been admitted to the mental hospital and become long-stay. They receive intensive and continuous community-based care (out-patient care, home visits and crisis intervention, day care) and have spells of admission to hospital (the psychiatric ward of the general hospital or the private psychiatric hospitals) when necessary. In all settings but the private hospitals they remain under the care of the same team.

LONG-TERM PATIENTS WITH FREQUENT CONTACTS WITH PSYCHIATRIC SERVICES
(ratios per 1,000 adult South-Verona residents)



6.4 Monitoring service utilisation over the years and comparing South-Verona area with other areas with different systems of mental health care.

The South-Verona PCR has been used in several studies conducted so far to monitor service utilisation and patterns of care. It has been shown that patients with a diagnosis of psychosis are more likely than other patients to be both higher users (those who have many contacts in a defined period of time, for example one year) and long-term users (Tansella et al., 1986). Service utilisation measures for the period 1983-89 were used to identify associations with socio-demographic variables from the 1981 census. The most strongly associated predictor

variables, both for schizophrenia and all diagnoses were: living alone, unemployment, percentage of the total population who is dependant, and percentage divorced, separated or widowed. Stepwise multiple regression models using three census predictors accounted for over 85% of the variance in South-Verona utilisation rates (Thornicroft et al., 1993). On the other hand no consistent patterns in the associations between local social and demographic predictors and rates of service utilisation were found for patients with a diagnosis of neurosis or somatoform disorder (Tansella et al., 1993).

Patterns of care in South-Verona have been compared with those in four other areas in Italy (Balestrieri et al., 1992) in Aarhus, Denmark (Munk-Jorgensen & Tansella, 1986), Groningen, The Netherlands (Sytema et al., 1989; Balestrieri et al., 1989) and Manchester (Gater et al., 1995; Amaddeo et al., 1995a

A case register study was recently completed to address the question whether the delivery of continuity of care is different in a community-based system of care (South-Verona, Italy) as compared with a hospital-based system (Groningen, Holland). The continuity of care was measured by means of two indicators: readiness of aftercare (the time from discharge from hospital to the first day- or outpatient contact) and flexibility of care (the combination of in-, day- and out-patient care during a two-year follow-up). All patients contacting the services at least once in 1988 (in Groningen) and in 1988 or 1989 (in South-Verona) were included in the study and followed for 730 days, starting with the first contact. Both indicators showed a higher continuity of care in South-Verona. Survival analysis was used to correct for censoring. It showed that the median time from discharge to aftercare contact was significantly shorter in South-Verona (6 days) than in Groningen (9 days). Cox regression analysis revealed that in both systems a contact before admission, the time between this contact and admission and the duration of admission are predictors of aftercare. A higher percentage of patients made multiple service use (combinations of in-, day- and out-patient care) in South-Verona than in Groningen (62% vs. 45%) (Sytema et al., 1997).

[redacted]

7. THE OUTCOME PROJECT

In mental health services, especially those organised according to the population-based approach, a systematic evaluation of the care provided should be both preceded and followed by long-term monitoring of service utilisation and of patterns of care (Tansella & Ruggeri, 1996). Rational planning, based on evidence as well as on ethical principles, needs a continuous cycle of monitoring and evaluation. In South-Verona we are trying to follow this approach to service evaluation.

In the last few years we developed an integrated model for assessing the outcome of care routinely: the South-Verona Outcome Project. In this model, variables belonging to four main dimensions are considered: clinical variables, social variables, variables concerning the interaction with services (specifically, needs for care, satisfaction with services, family burden) and data on service utilisation and costs. Both quantitative and qualitative measures are used and the assessment for the latter is multiaxial, i.e. takes into account the perspectives of patients, relatives and professionals.

The project is an attempt to standardise information that clinicians collect and record, in periodic reviews of cases in treatment in their everyday clinical practice, and to employ for service evaluation the same professionals involved in the clinical work. Most of the assessments are actually completed, after a short training, by the clinicians themselves, some other assessments are made by the patients, with the help of research workers. The aims of the South-Verona Outcome project are:

1. To study the outcome of community care using a naturalistic and longitudinal approach in evaluating outcome;
2. To identify topics of interest for experimental studies;
3. To promote standardisation of routine clinical assessments, i.e. to improve the quality of the clinical records.

Standardised assessments take place twice a year: from April to June (wave A) and from October to December (wave B). During these periods both first-ever patients and patients already in contact with the service are assessed at the first or, at latest, second time they are

[redacted]

seen. In wave A the assessment is made only by the key professional (in most cases a psychiatrist or a psychologist) and includes the Global Assessment of Functioning Scale (GAF, Endicott & Spitzer, 1976), the Brief Psychiatric Rating Scale (BPRS, "expanded version", Lukoff et al., 1986), 8 items from the Disability Assessment Scale (DAS-II, WHO, 1988), and the Camberwell Assessment of Needs (CAN, Phelan et al., 1995). In wave B the assessment is made both by the key-professional (again GAF, BPRS, and DAS) and the patients, who are requested to complete the Lancashire Quality of Life Profile (LQL, Oliver, 1991) and the Verona Service Satisfaction Scale (VSSS, Ruggeri & Dall'Agnola, 1993; Ruggeri & Greenfield, 1995). Quantitative data on socio-demographic characteristics, psychiatric history and service utilisation are routinely recorded in the South-Verona PCR. All these data are put into the clinical records and are available on line to clinicians.

The project started in 1994 and about 80% of the patients in contact with the service in that year has been assessed in both waves. The mean time used by the professionals for the assessment was 26.9 minutes for each patient, with a wide range (8-70 minutes), depending on the type of patient and on the severity of their condition.

As an example, summary preliminary data regarding the assessments made in wave B of 1994 are reported here. A comparison of results obtained in the group of psychotic patients (those with a diagnosis of schizophrenia, schizotypal and delusional disorder, affective disorder, or organic psychosis) and non-psychotic patients showed:

a. Significantly ($p<0.001$) higher psychopathology in psychotic patients in all items of the BPRS except in those regarding anxiety and depression. Less than 10% had severe symptoms.

b. Significantly ($p<0.001$) higher disability in psychotic patients in all items of the DAS. Less than 15% had severe disability.

c. A trend for higher self-reported quality of life in psychotic patients. About 40% of patients reported dissatisfaction with their life.

d. No significant differences in satisfaction with services between psychotic and non psychotic patients. Satisfaction with South-Verona CPS was high, with a better performance on items concerning professionals' behaviour/manner and a relatively

worse performance in the areas of information received and access to service.

These data indicate that in South-Verona the diagnosis of psychosis is not necessarily a marker for unfavourable life circumstances and that the South-Verona CPS meets the demands of psychotic patients. Moreover, they indicate that the perspective of patients and professionals convey complementary points of view.

The work in progress in South-Verona is aimed at understanding the relationship existing between quantitative and qualitative variables, and their predictive value for the long-term outcome of care. We are trying to identify valid patterns of outcome indicators for specific groups of patients using multidimensional and multiaxial outcome monitoring as an integral part of patients' care (Biggeri et al., 1996)..

8. STUDIES FOR EVALUATING COSTS

All patients (N=706) who in 1992 had at least one contact with services reporting to the South-Verona psychiatric case register and received an ICD-10 diagnosis were included in a study to evaluate direct costs of care. The costs of specialist psychiatric care provided in the 365 days following the first 1992 contact were calculated using a unit cost list described elsewhere (Amaddeo et al., 1995b). For each patient, costs were calculated using a dedicated software, linked to the case register and designed by our research team and were grouped by in-patient costs, sheltered accommodation costs, day-care costs, out-patient costs and community costs. The results can be summarised as follows (Amaddeo et al., 1997b):

a. All costs, grouped by service type, were found to be significantly different ($p<0.01$) between diagnostic groups.

b. The multivariate analyses showed that costs are significantly higher for people with a diagnosis of schizophrenia and related disorders than for people belonging to the other diagnostic groups. However, only 6 per cent of the variation could be explained by diagnostic group alone. On the other hand, between 37 and 53 per cent of the costs of mental health care was predicted by patients' personal characteristics and other measures recorded on the case register.

One of the main variables accounting for differences in costs between patients is previous psychiatric history, patients with longer or chronic history having higher costs. In areas where a shift has taken place from a hospital-based to a community-based system of psychiatric care it is interesting, for both policy makers, planners and managers, as well as for clinicians, to evaluate costs of new patients, i.e. patients having their first life time psychiatric contact, for at least two reasons: First, the costs of this sub group of patients is not subjected to interference from previous encounters with psychiatric services, including those in the old hospital-based system; lower between-patient variability and higher predictive values of cost equations can therefore be expected. Second, these patients have patterns of care that are different from those of other patients, i.e. patients already known to the services, especially the most chronic. Their service use, as well as their outcome of care, therefore needs to be assessed separately from those of other patients, in order to evaluate properly the efficacy of clinical programmes, as well as to decide the most efficient allocation of resources. To our knowledge no studies so far have analysed the costs of patients at the first psychiatric contact in their life (first-ever patients). We therefore carried out an epidemiologically-based research on South-Verona first-ever patients.

Direct costs of care provided in the 365 days following the index contact were assessed for all first-ever patients (N=299) and (for comparison) for all longer-term patients (N=768) who had at least one contact with psychiatric services over a two-year period (from January 1992 to December 1993). The results can be summarised as follows (Amaddeo et al, in press):

a. Although the unit cost for each service need to be calculated carefully (and recalculated from time to time), and this can be quite time consuming, it is confirmed that PCR data can be supplemented with cost indicators in order to build up descriptive statistics on the financial implications of the varying service utilisation patterns. The software that we developed for our case register can greatly simplify the procedure and can make not only the calculation of costs, but also the aggregation of data by type of treatment, separately for different groups of patients, straightforward.

b. First-ever patients, in the first year after the index contact, are significantly less costly as compared with all other patients in contact with the same services during an equivalent period of time. The reason for this difference is that first-ever patients have different patterns of care, as compared with longer-term patients. The cost difference is confirmed for all diagnostic groups taken into account in our research. When total

costs are disaggregated into their components, by type of treatment (i.e. in-patient care, day patient care, etc.) the difference is no longer significant for in-patient care of patients with a diagnosis of schizophrenia and for out-patient care in all four diagnostic group.

c. Known patients, as compared to first-ever, required, in all diagnostic groups, a similar amount of out-patient care, but more (and more expensive) day care and community care, which includes home visits by psychiatrists, as well as by nurses and social workers. These data confirm the experience of clinical practice that, for patients with a previous psychiatric history, all components of a community-based system of care are important, but the key component is not out-patient care, but domiciliary visits, day-care and rehabilitation programmes. The implication of these results for service organisation is that resources should be dedicated to ensure the provision of the above mentioned types of care, together with care provided by "traditional" out-patients departments.

d. Our data also confirm that, when analysing costs of care provided by specialist public services, there is a decreasing trend of costs from patients with diagnosis of schizophrenia and related disorders (the most expensive) to those with affective disorders and with other diagnosis. The least expensive are those with neurotic and somatoform disorders, probably because they also receive care from private psychiatrists and psychologists who do not report to the case register.

e. Between 20% and 69% of the observed inter-patient cost variation is explained statistically by individual characteristics included in cost functions. The lowest percentage of the variance explained was found in the diagnostic group "other diagnosis", which is a mixed, not homogeneous group, which includes patients with a miscellany of different diagnoses. On the other hand, the variance explained by individual characteristics, in more homogeneous groups, such as the group of patients with schizophrenia and related disorders, is much higher (69%).

In patients who contact a specialist psychiatric service for the first time in their life, variables with a higher predictive power, when controlling for other variables, are age (older patients with neurotic or affective disorders are less costly), gender (males with affective disorders cost more), marital status (single people with schizophrenia cost more, as do single males with neurosis), unemployment (males with neurotic and somatoform disorders are more costly) and referral (patients with affective disorders referred by non-psychiatrists specialists were less costly and neurotic patients referred by relatives were more costly).

f. Analysing the costs of all patients with a diagnosis of schizophrenia and related disorders who had at least one contact in the two year period 1992 1993, we found that for more than 90 % of patient the costs are lower than those of continuous one year stay in a State Mental Hospital ("*manicomio*"). For 3.6 % the costs are higher than those for continuous one year stay in a "*manicomio*" and lower than those for one year stay in a private psychiatric clinic For 3.1% the costs are higher than those for one year stay in a private clinic and lower than those for one year stay in a

psychiatric ward of a general hospital. Finally, for 3 % of patients the costs are higher than those of one year of continuous care in the most expensive in-patient institution.

g. A gradient of costs emerged when grouping patients into: those with no previous episodes of care (N=457), those with less than three years of care (N=122) and those with three years or more of contacts with psychiatric services (N=443). (For 45 out of the 1067 patients which constitute the 1992-1993 cohort the information was missing). Patients with a longer psychiatric history cost significantly more than shorter-term patients.

Two limitations of the studies reported above have to be underlined (Amaddeo et al., 1997b). First, being case register studies, only costs of care as provided by the specialist psychiatric system, i.e. by services and agencies reporting to the case register, not the total societal costs are assessed. Second, the cost evaluation was limited to the first year following the index contact; no information were provided on costs of psychiatric care over longer periods. While it would be easy to solve the second problem, using the present methodology in this or in a similar cohort of first-ever patients followed for a longer period of time, the first limitation can be unravelled only using appropriate instruments such as the Client Service Receipt Interview (CSRI) (Beecham & Knapp, 1992) and a prospective research design. Both types of research are actually in progress in Verona.

9. CONCLUSIONS

We have described in this chapter the current organisation of the South-Verona CMHS and its history and we have reported the results of the main studies completed so far to monitor and evaluate the service. It is often stated that it is now necessary for health services, including services for the mentally ill, to provide accurate, routinely collected data on the clinical activities carried out and their outcome, in order to evaluate them. It is also widely recognised that these data, to be compared with those from other areas, should be epidemiologically based. To conclude this chapter we should stress that both monitoring and evaluating mental health services using an epidemiological approach require extra financial resources and availability of scientific competence and skills. Therefore, before embarking on such a programme, its costs and the practicability of implementing and running it should be carefully evaluated. The advantages of this policy are clear: it may assist the

administrators in deciding what services are cost-effective (which should not be misused for cost-saving) and it makes it possible to mental health professionals to ensure that the evidence-based foundation for planning and evaluating mental health services is counter-balanced by ethically based clinical values; these values, as for example accountability, accessibility, co-ordination, continuity of care, should be made explicit and confirmed by the general organisation of the service as well as by monitored daily service activities. (Tansella & Thornicroft, 1997; Thornicroft & Tansella, in preparation).

ACKNOWLEDGEMENTS

We are grateful to our many colleagues in the Institute of Psychiatry of the University of Verona as well as in many other scientific institutions in Italy and abroad who helped us in collecting data and in the analyses and collaborated in the evaluative studies conducted in the last 18 years in South-Verona. They are too many and it is impossible to mention them all.

The main evaluative studies reported here have been funded by the *Ministero dell'Universita e della Ricerca Scientifica, Roma*, by the *Consiglio Nazionale delle Ricerche (CNR), Roma* and by the *Assessorato alla Sanita, Regione Veneto, Venezia*. The preparation of this chapter was supported by the *Fondazione Cassa di Risparmio di Verona Vicenza Belluno e Ancona, Progetto Sanita* 1996-1997, Grant "The role of social factors on onset, course and outcome of mental disorders: An epidemiological approach" to Professor Michele Tansella.

REFERENCES

Amaddeo F., Beecham J., Bonizzato P., Fenyo A., Knapp M.J.R. & Tansella M. (1997a). The use of a case register for evaluating the costs of psychiatric care Acta Psychiatrica Scandinavica 95, 189-198.

Amaddeo F., Bonizzato P. & Tansella M. (1997b). Psychiatric case registers for monitoring service utilisation and evaluating its costs. In Making Rational Mental Health Services, ed. M. Tansella, pp. 177-198, Roma: Il Pensiero Scientifico Editore.

Amaddeo F., Beecham J., Bonizzato P., Fenyo A. Tansella M. & Knapp M.. The cost of community-based psychiatric care for first-ever patients. A case-register study: Psychological Medicine (in press)

Biggeri A., Rucci P., Ruggeri M. & Tansella M. (1996). Multidimensional assessment of outcome. The analysis of conditional independence as an integrated statistical tool to model the relationships between variables. In Mental Health Outcome Measures (ed. G. Thornicroft & M. Tansella), pp. 207-216. Springer-Verlag: Heidelberg.

Sytema, S., Micciolo, R., & Tansella, M. (1997). Continuity of care for patients with schizophrenia and related disorders: a comparative South-Verona and Groningen case-register study. Psychological Medicine, in press..

Tansella M. (Ed.) (1991). Community-based Psychiatry: Long-term Patterns of Care in South-Verona.. Psychological Medicine Monograph Supplement 19. Cambridge: Cambridge University Press.

Tansella M. (1993). The Research Unit of the Servizio di Psicologia Medica at the Institute of the University of Verona, 1980-1991. Psychological Medicine 23, 239-247.

Tansella M. & Ruggeri M. (1996). Monitoring and evaluating a community-based service. In The Scientific Basis of Health Services, ed. R. Smith & M. Peckham pp. 160-169, London: British Medical Journal Publishing Group

Tansella M. & Thornicroft G. (1997) A conceptual framework for mental health services: the matrix model. Psychological Medicine, in press.

Tansella M. & Williams P. (1989). The spectrum of psychiatric morbidity in a defined geographical area. Psychological Medicine, 19, 765-770.

Tansella M. & Zimmermann Tansella Ch. (1988). From mental hospitals to alternative community services. In Modern Perspectives in Clinica Psychiatry. ed. J.C. Howells, pp. 130-148. New York: Brunner Mazel.

Thornicroft G. & Tansella M. (in preparation). Re-Forming Mental Health Services. A Pragmatic Guide. Cambridge: Cambridge University Press.