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Research and Context Analysis COMPARATIVE TRANSNATIONAL REPORT

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Introduction

The historical development of Mental Health System in the 6 considered countries is characterized by a not so rapid but constant shift from the traditional system of care "in-patient", which provided long term hospitalization in big hospital facilities, to a community-based system of care. Within community-based system the primary care is usually given by decentralized facilities, sometimes connected with local general hospitals, which can offer different kind of services, while big hospital facilities, expansive and inefficacious for rehabilitation, tend to be substituted by small non-hospital residential facilities of various kinds and with different intensity of care. From this point of view, within a modern system of psychiatric care non-hospital residential facilities would become very important, considering that de-institutionalization process bring with it the necessity to take in consideration the needs of so-called long term patients, which need care during all the course of their life.

This change toward community-based system brings with it important implications, both in organization of the systems both in approach to caring.

The main difference with the traditional approach can be synthesized in the following scheme:

Community-based System	Traditional system
De-institutionalization	Institutionalization
Local administration	Central administration
Out-patience care	In-patience care
Psycho-social approach	Medical approach

How we are going to see, in the 6 considered country, the change of the system tend to follows the direction meant by the scheme. So, we can say that all the considered country are going toward a community-based system. Just the time and the way of this process are different country by country. Actually DI process development appears to be conditioned by many factors, mostly

historical and political . Then, in each country, DI process starts at different times and develops within different contexts.

Various factors influence the way and the times of this process:

- **Historical factors**
 - History of psychiatric care
- **Socio-cultural factors**
 - Attitude towards mental illness
- **Economical-political factors**
 - Choices of economic policy
 - Choices of health policy
- **Structural factors** (directly related to economical-political choises)
 - Lack of an adequate social care system which are, in some case, replaced by Psychiatric hospitals
 - Need of residential features for long-term patients

1.1 Greece

In Greece, till 1980 highly centralized structure, as well as inadequate primary care and rehabilitation facilities has characterized the mental health care system. The organization of the mental health hospitals was anachronistic and failed to serve the needs of the population. Most institutions were placed in Athens and Thessaloniki, while those in other areas served mainly as “warehouses” of chronic mental patients.

Process of de-institutionalization starts in the 80's. In 1984 de-institutionalization of “Leros State Hospital”

Over the past twenty years, there has been a significant decline (59%) of beds in public psychiatric hospitals, which has been combined with the development of community psychosocial rehabilitation facilities (with a 107% increase in settings over the same period). This depicts the gradual but consistent move of patients from institutionalized settings to more community-based environments.

Since 2000 has been working the Psychargos Program which provides, by 2015, the closing of the 9 remaining psychiatric hospitals. At present, this program is in full implementation.

1.2 Italy

In Italy, process of de-institutionalization starts in the mid-late of '60. In 1978 law 180 provides prohibition of new admissions in Psychiatry Hospitals and planning and building the new community-based services. By then there has been a constant decrease in number of residents in Psychiatric Hospital. This decrease is most evident between 1978 and 1982 and between 1994 and 2000. By 2000 the DI process may be considered fully accomplished.

Unfortunately, the development of the community-based services planned by the law, depending on regional management, has been different in the different areas of the countries. In general it can say that established services are not enough to take in care the suffering persons adequately. That is true in particular in the less developed areas of the South of the country.

Another critic point emerged after closing of psychiatric hospitals is the need of residential solution for long terms patience, that patience which need to be taken in care during all their life and especially need a place to stay because they haven't got or because they can't live with their family. Talking of this, by Italian experience it can say that closing mental hospitals is an important part of a process of change of traditional systems of care, but have to be followed by a parallel and capillar process of building of community-services, which also take in account the need of long-term patience

1.3 Latvia

In Latvia, as in Czech republic, political changes have favoured since the beginning of '90 a process of change within the conception of psychiatric care. The transition from the totalitarian regime to democratic society and market economy and the relatives reforms have affected all socio-economical aspects of Latvia. Health care and psychiatry has been involved in this process. At this time In Latvia psychiatry is undergoing the process of decentralization, specialists are acquainted themselves with new methods of treatment and mental care, and are also striving to find their unique way for further professional development. The process of deinstitutionalization is an important part of this change and started immediately after the Restoration of Latvian Independence; however, it has been especially rapid during the last 5 years. At present the reduction in the number of hospitals and their capacity is not admissible given the current insufficient development of social care institutions. Today the work at hospitals is intensified to the maximum (bed occupancy has increased, average number of bed-days has decreased).

1.4 Scotland

Scotland has a long and varied history concerning the care, treatment and support of people with mental health problems. Taking a UK and Scottish perspective we can see that the first recorded instance of care was in 1377 when Bethlem (sometimes called bedlam) was used for the detention of "lunatics". So, considering the other countries, the process of de-

internalization of psychiatric patient care starts very early in Scotland. Already in 1949 there has been the first experience of "open door policy" at Dingleton Hospital, Melrose. The medical superintendent, Macdonald Bell (G.M. Bell) published a paper "A mental hospital with open doors". By then there has been a slow but constant process of development of ID process and a constant decrease of resident in PO. In the 80's and 90's DI process was at his top and there has been the major changes toward community-based care.

1.5 The Czech Republic

In Czech Republic the process of change of psychiatric care system starts at the end of the '80, after political changes in 1989 ("velvet revolution"). Since 1990 to 1995 more than 3500 beds in psychiatric hospitals has been closed. At the same time starts the development of community-based mental health services, by NGOs which operate in the country since 1990. After 1995 this process of change has been retarded and in general traditional institution care is changing slowly. Political factors influence the process. Official mental health policy started just in 1995, and has produced as final result the *Concept of Psychiatry*, accepted by the Ministry of Health board of professionals in 2001. This document reflects the times of its origin: in one hand is a step toward a more advanced way of caring for people with mental illness, but in other hand it is still strongly rooted in the "traditional" psychiatric care.

At the present there is in act an important change. In fact, from 01/01/2007 the responsibility for planning and provision of social care will be fully transferred to the regional and local level. It means that most community rehabilitation services will be planned and supported on regional/local level.

1.6 The Netherland

In The Netherland the development of Social Psychiatric care proceeded gradually during the last decades.

Instead of closing down psychiatric hospitals for long term patients, in The Netherlands the number of psychiatric hospital beds were only cut down by 15 to 20 percent during the last 25 years. At the same time an increase in

sheltered housing took place. So, in the Netherland the change of Psychiatric system appears to be gradual and less radical compared to countries as the US, the UK and Italy. The reasons for this difference are numerous.

The most important reason is related to a political choice of Dutch Government. In the late seventies and early eighties, when most of the de-institutionalisation laws came in force, Dutch government judged that the general situation in psychiatric hospitals needed improvement (better housing and more privacy for patients) but was not considered inhumane. So psychiatric hospitals were not forced to undergo revolutionary changes. While in other countries the need for alternative psychiatric care was urgent as a result of de-institutionalisation, new care programs for long term patient were only developed slowly in The Netherlands during the eighties and nineties. Instead of a shift from clinical to ambulatory care, management and politicians choose a gradual integration of the different mental health care provisions on a voluntary basis. Thanks to some governmental incentives (i.c. care innovation funds) and slight pressure by societal debates, changes got accelerated during the last ten to fifteen years.

Tab.1 Historical Development of de-institutionalization process

GREECE	It starts in the 80's. In 1984 de-institutionalization of "Leros State Hospital" In 2000: Initiation of the Psychargos Program which provides, by 2015, the closing of the 9 remaining psychiatric hospitals. At present, this program is in full implementation.
ITALY	It starts in the mid/late 60's. In 1978 law 180 provides prohibition of new admissions in Psychiatric Hospitals and planning and building of new community-based services. By then there has been a constant decrease in number of residents in Psychiatric Hospitals. This is most evident between 1978 and 1982 and between 1994 and 2000. By 2000 the DI process may be considered fully accomplished.
LATVIA	It Starts in early 90s after Restoration of Latvian Independence. Especially rapid during the last 5 year. At present the reduction in the number of hospitals and their capacity is not admissible given the current insufficient development of social care institutions. Today the work at hospitals is intensified to the maximum (bed occupancy has increased, average number of bed-days has decreased).

SCOTLAND	It starts in the late 40's. In 1949 first experience of "open door policy" at Dingleton Hospital. Melrose. The medical superintendent, Macdonald Bell (G.M. Bell) published a paper "A mental hospital with open doors" By then there has been a slow but constant process of development of ID process and a constant decrease of resident in PO. In the 80's and 90's DI process was at his top and there has been the major changes toward community-based care.
THE NETHERLANDS	It Starts in the late 70's. Instead of closing down psychiatric hospitals for long-term patients (the number of psychiatric hospital beds were only cut down by 15 to 20 percent during the last 25 years) DI process develops slowly through implementation of new community-based care programs for long-term patients.
THE CZECH REPUBLIC	It starts in the early 90's after political changes ("velvet revolution"). Traditional institutional care are changing slowly. As compensation community based mental health services are established by NGOs. Despite of development of these new approaches and new providers, comparing to biological or psychotherapeutical treatment, community-based rehabilitation for mentally ill is still only little disseminated.

2. LAW AND LEGISLATION

Introduction

A specific law about mental health is not present in all the considered countries. In some country there are some guide-lines or basic regulation, but not translated in a legislation that regulate the organization of the system.

In general it can says that a constant trend in legislative changes, parallel with DI process, go towards devolution to the regional and local authorities of responsibility for planning and provision of the services. Unfortunately, despite to good intentions, in some case in official health policy there is still some resistance to accept a modern approach to psychiatric care or dangerous tendencies by some political party to restore old ways, as in Italy, where the process of change has been radical and by now concluded.

In some case, there is a gap between official government policy , characterized by a medical approach, and community- based organization of the services managed by NGOs or different kinds of private enterprise. That can produces problems in connection and communication between Central government and care providers. These problems can have repercussions on the organization of the system and, directly, on the quality of the care given to the suffering persons.

The risk that it runs, in this case, is to develop a system fragmented into two parts, which operate under different principles and without the necessary connection.

2.1 Greece

In 1983 **Law 1397** established the National Health System. This law included provisions for the creation of the infrastructure required for the modernization of Public Psychiatry. It has been criticized in several publications.

In 1984 **Regulation 815/84 of the European Community for the co-funding of the Hellenic Psychiatric Reform**. Projects "Leros I and II" for

the deinstitutionalization of the “Leros State Hospital” and the PIKPA Institution (Welfare Unit for Handicapped Children) of the island.

In 1999 **Law 2716** regarding the “Development and Modernization of Mental Health Services”. It promotes the sectorization of the Mental Health Services of the country. It legalizes all the alternative to hospitalization community mental health facilities which have been recently developed.

In 2000: Initiation of the Psychargos Program co-founded with the European Union. The Program organizes the abolition of 5 Mental Hospitals and the development of a wide range of community mental health services as well as General Hospital mental health units.

2.2 Italy

In Italy specific law about mental health is **Law 180/1978** that mostly provide:

- Prohibition of new admission in Mental Hospital
- Planning and building of new community-based services, at regional level
- Dismantling of old Mental Hospitals
- Admission for acute care only in Psychiatric small wards in general hospitals for short term periods

Mental Health plan 1994-1996 that provided the establishment of Departments of Mental Health (DSM) in all the Local Health Units (ASL).

Mental Health Plan 1998-2000: the most recent mental health program issued by the Ministry of Health aim to define better the mission of DSMs through implementation of projects with connect services with citizens who need care. Criting points of this plan are:

- Involvement of the families in rehabilitation plans (Involvement has to be voluntary and the service keeps responsibility of caring)
- Involvement in rehabilitation of severe users which break the appointments and loose the service, to reduce suicide risk.
- Supporting creation of self-help groups and social firms finalized to working insertion of the users.

2.3 Latvia

There is not a specific legislation about mental health in Latvia. Actually, mental health care in Latvia is regulated by the Law on Public Health. Despite to recommendation given by the WHO in order to improve the current situation in the field of mental health, in Latvia the development of mental health enforcement policy is going slowly. Basic regulations **“The Amelioration of the Population’s Mental Health in 2006 – 2016”** have been worked out, but they are still under consideration. Regulations have been drawn up on the basis of the WHO 2001 report on the health state in the world and on the basis of the priorities in the field of health specified in the 2005 Helsinki declaration. Methodological basis for psychiatric services is ensured by the Mental Health Governmental Agency.

2.4 Scotland

There is a specific legislation. At present the main laws in force are:

- The **Mental Health Care Treatment Scotland Act 2003**, which came into effect on 5th October 2005. It mostly says:
 - When a person can be taken to hospital against his/her will
 - When a person can be given treatment against his/her will
 - What rights a person has when they are receiving care and treatment
 - What safeguards are in place to protect a person's rights

The law is based on a set of principles. which aim to safeguard the rights of the suffering person. These principles should be taken into account by anyone involved in a person's care and treatment

- **Adults with Incapacity (Scotland) Act 2000**,

By this law, if an adult is unable to make a safe decision about his or her own welfare, a court can appoint a 'welfare guardian' to make decisions for him or her.

Other laws related to the issue are:

- **Convention Rights (Compliance) (Scotland) Bill (2001)**

- **Regulation of Care (Scotland) Bill (2001)**. The Regulation of Care (Scotland) Bill creates a new system for the regulation and inspection of care and early education services, as well as the workforce who provide these services. It does this primarily by the establishment of two new non-departmental public bodies:

- The Scottish Commission for the Regulation of Care (The Commission)
- The Scottish Social Services Council (The Council)

2.5 The Czech Republic

There is much legislation linked to the mental health care, but there is not a specific law. The official policy exists, accepted by the Ministry of Health in 2001 (the *Concept of Psychiatry*). This document, how we have already said, is a step toward a modernization of the way of caring people with mental disease is still but is still strongly rooted in the traditional psychiatric care. Moreover there is not legislation establishing the types of services.

The main laws related to psychiatric care are:

- **Retirement insurance** which mainly regulates invalidity pension and work rehabilitation of citizens with restricted working capacity.
- **Substantive civil law** which regulates detention procedure, custody, legal competency.
- **Administrative law- medical field**, which regulates mainly: agreement with treatment, conditions for psychiatric detention, conducting medical files, complaints concerning treatment, legal basis of hospital rules.
- **Substantive criminal law** which regulates necessary defence, insanity in connection with responsibility for committing a crime,
- **Criminal law of procedure** which, concerns mainly obligatory legal defence and protective treatment (especially institutionalized).
- **Medical care**, which regulates:

- conditions and scale of medical treatment provided at private healthcare facilities as well as conditions for operating a private healthcare facility
- rights and responsibilities in the field of public healthcare
 - **Social care** will come into effect 1.1.2007; it regulates rights and responsibilities in the field of social services as well as it establishes general typology of social services.

2.6 The Netherlands

Nowadays major changes in legislation concern the financing of the system. Until 2006 all payments for mental health care were based on the **Exceptional Medical Expenses Act (AWBZ)**, except for **Public Mental Health Care (OGGZ)** (in case of emergency; some public prevention activities), and psychiatric care by general practitioners. From 2007 all ambulatory care, and all hospital care up till one year will be paid according to the new **National Insurance Act**, obligatory for all the citizens. Moreover municipalities will get responsibilities to support all vulnerable citizens in order to enable them to live independently within society.

Exceptional Admission Act (BOPZ), much discussed by the psychiatrists, is a law that tries to control involuntary or compulsory admissions and the rights of patients at the same time.

Other important laws for patients are

- **The Medical Treatment Agreement Act (WGBO)**, that regulates the agreement between doctor and patient about treatment.
- **The Institutional Client Participation Act (WMCZ)**. Every care institution is obliged to install a client council. Decisions on many topics, even concerning the staff, must be advised by this council. Nowadays monitoring the quality of care is one of the major tasks of the client councils.

Tab.2 Legislation

GREECE	<ul style="list-style-type: none"> - Legislation 1397 (1983): Constitution of the National Health Care System - Legislation 2716 (1999): Development and modernization of the Mental Health Services (Sectorization) - Legislation 2889 (2001): Foundation and Operation of the Regional Health Care System - «PSYCHARGOS» program (2001-2010), that provides the gradual abolition of the Psychiatric Hospitals which yet operate in the country.
ITALY	<p>Law 180/1978 that mostly provide:</p> <ul style="list-style-type: none"> - Prohibition of new admission in Mental Hospital - Planning and building of new community-based services, at regional level - Dismantling of old Mental Hospitals - Admission for acute care only in Psychiatric small wards in general hospitals for short term periods - Mental Health plan 1994-1996 that provided the establishment of Departments of Mental Health (DSM) in all the Local Health Units (ASL) - Mental Health Plan 1998-2000: the most recent mental health program issued by the Ministry of Health
LATVIA	<p>There is not a specific law. Mental health care in Latvia is regulated by the "Law on Public Health". As compensation there are Basic Regulations "The Amelioration of the Population's Mental health in 2006-2016", but they are still under consideration.</p>

SCOTLAND	<p>There is a specific legislation. At present the main laws in force are:</p> <ul style="list-style-type: none"> - The "Mental Health Care Treatment Scotland Act 2003", which came into effect on 5th October 2005. <p>This law is based on a set of principles. which aim to safeguard the rights of the suffering person. These principles should be taken into account by anyone involved in a person's care and treatment</p> <ul style="list-style-type: none"> - "Adults with Incapacity (Scotland) Act 2000"
THE CZECH REPUBLIC	<p>There is much legislation linked to the mental health care, but there is not a specific law. The official policy exists, accepted by the Ministry of Healt in 2001 (the Concept of Psychiatry). but there is not legislation establishing the types of services . An important change is going to be: in fact, from 1.1.2007 the responsibility for planning and provision of social care will be fully transferred to the regional and local level.</p>
THE NETHERLANDS	<p>At present, an important change is going to be made in legislation, particularly in financing the system. Till now all payments for mental health care were based on the Exceptional Medical Expenses Act (AWBZ), except for Public Mental Health Care (OGGZ). From 2007 all ambulatory care, and all hospital care will be paid according to the new National Insurance Act, obligatory for all citizens. Besides municipalities will get responsibilities to support all vulnerable citizens. Other important laws for patients are:</p> <ul style="list-style-type: none"> "The Medical Treatment Agreement Act (WGBO)" "Institutional Client Participation Act (WMCZ)".

3. SERVICES ORGANIZATION

3.1 Greece

At this time organization of community-based services is in full implementation. The country has therefore been divided into Mental Health Sectors. Each prefecture is a Sector. At the level of structures and services, the goal set by the Mental Health Reform Guidelines was (and still is) to develop *a comprehensive network of services in the community that will ensure the adequate functioning of the regional public health services with regard to the needs of the local population – a goal that is clearly far wider-reaching than the mere treatment of illness.*

General objectives of the Reform are:

- 2001-2006

1. Closing of 5 Psychiatric Hospitals out of a total number of 9 that exist in the country. Transfer of Care and Services provided in General Hospitals and Community-based Services.
2. Reduction of the Capacity (number of beds) of the remaining 4 Psychiatric Hospitals at a level of 50% of their initial capacity.

2007-2015

1. Closing of the remaining 4 Psychiatric Hospitals

Processes for the Implementation of the National Policy

The Ministry of Health & Welfare has issued ministerial directives defining what should be done at all administrative levels, regions, time periods and by which participating agent

The two main community services to be introduced in the new system were the Community Mental Health Centres and the Psychiatric Units in the General Hospitals

In a survey that has been carried out by the Psychargos Phase II Monitoring and Support Unit (not yet published) it was found out that on December 31st 2005 there were 377 residential facilities all over Greece, created since 1988, 28.6% of which run by NGOs (there are 33 NGOs involved

in Psychargos Phase II programme) and 71.4% by state mental or general hospitals.

3.2 Italy

The National Health Service (SSN) in Italy is divided into three levels:

- Ministry of Health (national level)
- The Health Funds, composed of equal contribution of National Insurance and public revenue, which finance the Health Service
- The Regional Administration, which carry out the regional health planning and distribute finances at local level

The **Department of mental health (DSM)** is the cornerstone of public psychiatry care in Italy. It includes all public psychiatric facilities for adults in each of the 226 **Local Health Units (ASL)** of the 21 Italian regional districts.

In a DSM there are one or more **Mental Health Centers (CSM)**, which provide community services in a specific district for 12 hours a day/6 week.

The **Psychiatric Wards** in General Hospital (**SPDC**) by law is the only facility for voluntary and compulsory psychiatric hospitalization. A **Day Hospital** may be either an out-side hospital facility or it may be a facility run in collaboration with the SPDC within a general hospital.

Other services connected to DSM are the 612 **Day Centers** which therapy, rehabilitation, and vocational services based on individual projects.

The **Residential facilities** cover different kind of services: from home like facilities providing care a few hours a day to Therapeutic and Rehabilitative Communities providing intensive and permanent care. There is 1.552 on the whole with 17.101 beds. The most part is public: 912 (58%); 255 (16.4%) are private, while 52% are directly managed by the Department of Mental Health; 385 (24,8%) are operated by voluntary organization (NGOs) and 11% is under mixed public/private management.

3.3 Latvia

Considerable part of mental assistance to people with serious mental diseases and disorders is provided by the State.

The year 2004 has been characterised by a positive tendency in the development of a harmonised and logical health care system. As a result was established Mental Health Government Agency, which delegates additional responsibilities to this institution in the area of implementation of national mental health policy.

In 2004 the mental health care reform was continued, and the mental health care system was further developed and integrated into the community structure.

In outpatient departments the patient can consult the psychiatrist, receive prescriptions for medications, in case of necessity s/he can get a confirmation of his/her health condition. Moreover, the psychiatrist prepares all documents requested for decisions of a commission of experts. In outpatient establishments, besides a psychiatrist, there is a psychiatry nurse who is mainly in charge of documentation, assists to the doctor but does not work with patients independently.

In hospital conditions in Latvia, psychiatric assistance is ensured by 5 regional psychiatric hospitals, which can be considered acute hospitals as here the patients arrive not only with psychiatrist's prescription for planned treatment and investigation, but also in acute, emergency cases with ambulance assistance transport or police assistance

Community based mental health care system in Latvia is ensured by 4 outpatient psychiatric departments or ambulances at regional psychiatric hospitals, as well as 23 mental health care consulting – rooms at municipal medical institutions in the whole Latvia and 55 psychiatric practices of which 16 practices catered for the public procurement.

3.4 Scotland

The **National Health Service (NHS)** is the publicly funded healthcare system of the United Kingdom. The organisation provides the majority of healthcare in the UK. The NHS in Scotland has always been a separate and distinct body from the NHS in other parts of the United Kingdom. Healthcare policy and funding is the responsibility of the Scottish Executive. The chief civil servant in the Scottish Executive Health Department is also chief executive of NHS Scotland.

Provision of community care is the responsibility of 14 geographically-based NHS Boards.

Community Health Partnerships, or CHPs for short are the name of the new organisations that have been set up across Scotland to provide a wide range of community based health services delivered in homes, health centres, clinics and schools. These include mental health, health visiting, district nursing, speech and language therapy, physiotherapy, addiction and learning disability services.

Psychiatric services in Scotland are divided into 6 areas:

- Child and adolescent psychiatry
- Adult psychiatry
- Forensic psychiatry
- Learning disability
- Old age psychiatry
- Psychotherapy

Services are provided in the following settings:

- GP practices
- Community based psychiatric support
- Day hospitals (out-patient services)
- Psychiatric hospitals (in-patient services)
- The State Hospital (high security)

The voluntary sector is diverse, providing a variety of services and with staff providing many different roles, including support workers, advocates and befrienders.

All staff in the voluntary sector will eventually be registered with the Scottish Social Services Council (SSSC), and there will be a minimum qualification for each post. This has not been achieved yet. The SSSC is responsible for registering people in the social services field and regulating their education and training. They have published a Code of Practice that all workers must adhere to. This is overseen by the Care Commission. There are over 138,000 social service workers in Scotland.

3.5 The Czech Republic

In The Czech Republic psychiatric hospitals and some of the general hospitals are managed by the health ministry. Regions manage some general hospital. A change in organization of the system is going to be in act: from 1.1.2007 regional authorities and local authorities will take responsibility for planning and granting social services; this concerns main part of community based mental health services, as these services are mostly NGOs.

At the present in Czech Republic there are the following typologies of service (Based on the mapping of community services and traditional mental health care)

Hospital services and treatment

- Psychiatric hospitals for adults
- Psychiatric hospitals for children
- Psychiatric wards in general hospitals

Outpatient services

- Ambulatory Psychiatrists
- Clinical Psychologists

Community based services

- Crisis intervention centres and teams
- Day treatment programmes
- Day activity centres
- Work and employment support programmes

- Rehabilitation and sheltered workshop
- Social firms and social co-operatives
- Transitory employment
- Supported employment
- Housing support
 - Sheltered housing programmes (houses, flats)
 - Halfway houses and flats
 - Supported living programmes (in clients' own apartments)
- Case management teams
- Home care
- Users' information centres

In Czech Republic NGOs are the main initiators of the shift from institutional treatment to community based health care as they are the only providers of it. The precise monitoring of community-based services is still missing.

In 2001, Association of mental health community services has monitored 35 NGOs, providing community services for about 2 650 clients. The number of monitored NGOs has been probably lower than actual number of providers as the monitoring probably has not covered all providers (e.g. charities established by various churches were not included). The current number of NGOs providing community mental health care according newest monitoring is 69 organizations. We also estimate that number of clients taken care of is above 3 000.

3.6 The Netherlands

Health care in The Netherlands has always been a mix of public and private enterprise. Legally spoken all hospitals and facilities are privately governed and privately managed. But laws and regulations restrict the freedom of the care entrepreneurs.

Most of the mental health care facilities are regionally oriented in areas from 200.000 till 600.000 inhabitants (34 regions). Most regions have only one care provider for ambulatory and hospital care, rehabilitation etc.. These providers also manage most of the sheltered housing in their region.

During the last 5-10 years organisations for rehabilitation activities came into being. These organisations gather small facilities often started by (ex)clients themselves.

As one can understand from its historical background there is no clear separation between traditional and community care in The Netherlands. Traditional institutional hospital care developed very slowly toward a mix of psychiatric wards, ambulatory care, case management and outreach care, rehabilitation programmes and a range of long term housing.

Formally there are no community based mental health services in the Netherlands, as the general practitioner is gate-keeper for all care where medical specialists are involved. So citizens can not enter a mental health care facility without a referral.

At the other hand, during the eighties and nineties most of the mental health care facilities were transferred into the communities. In these often multifunctional centers all kinds of treatment and care can be provided, from psychotherapy for depression diagnosed clients to admissions for psychotic patients.

MHC-institutions provide most of the psychiatric care, that is available within the community. So this care is an undivided part of the regular care, as most of it has its origin within the MHC-institutions.

Within the MHC-organizations a rehabilitation movement became stronger and stronger during the eighties and nineties. As a result many subsidised projects on case management, vocational training, adapted jobs, job coaching, supported independent living, home care etc. got off the ground. Most of these projects are more or less adopted within the regular financing system.

The supplied psychiatric community care has the following aspects:

- crisis care: crisis intervention, clinical crisis admission, involuntary admission
- 'bed-on-receipt' 'time-out-bed' (voluntary crisis beds for short time-out periods)
- crisis card (not in every region): description of appointments between client, environment and caregivers in case of crisis

- case management
- all types of home care: intensive psychiatric home care, home support, assertive community treatment, meddling care etc.
- all forms of housing: sheltered housing, supported independent living, shelters for the homeless and roofless
- meeting centres, day activity centres
- working projects, adapted jobs, job coaching
- consumer run projects, run by volunteers or ex-clients (part time jobs)
- partner-groups, run by clients
- 'mates'-services (kind of buddy projects)
- sporting groups (i.c. walking and running)
- etc.

Tab.3 Organization

Greece	<p>The country has been divided into Mental Health Sectors. Each prefecture is a Sector (with the exception of certain small prefectures with limited population that are classified in the same Sector as a neighbouring prefecture that has a larger population).</p> <p>At the level of structures and services, the goal set by the Mental Health Reform Guidelines was (and still is) to develop a comprehensive network of services in the community that will ensure the adequate functioning of the regional public health services with regard to the needs of the local population – a goal that is clearly far wider-reaching than the mere treatment of illness.</p>
Italy	<p>The National Health Service (SSN) is divided into three levels:</p> <ul style="list-style-type: none"> - Ministry of Health (national level) - The Health Funds (financing level) - The Regional Administration (which carry out the regional health planning and distribute finances at local level)
Latvia	<p>Considerable part of mental assistance to people with serious mental diseases and disorders is provided by the State.</p> <p>In 2004 the mental health care reform was continued, and the mental health care system was further developed and integrated into the community structure.</p>

Scotland	<p>The National Health Service (NHS) is the publicly funded healthcare system of the United Kingdom.</p> <p>The NHS in Scotland has always been a separate and distinct body from the NHS in other parts of the United Kingdom.</p> <p>Provision of healthcare is the responsibility of 14 geographically-based NHS Boards.</p>
The Czech Republic	<ul style="list-style-type: none"> - State: The Health Ministry manages psychiatric hospitals and some of the general hospitals. - Regional and local authorities: Regions manage some general hospitals. <p>By 01/01/2007 regional authorities and local authorities will take responsibility for planning and granting social services; this concerns main part of community based mental health services, as these services are mostly NGOs.</p>
The Netherlands	<p>Health care in The Netherlands has always been a mix of public and private enterprise.</p> <p>Most of the mental health care facilities are regionally oriented in areas from 200.000 till 600.000 inhabitants (34 regions). Most regions have only one care provider for ambulatory and hospital care, rehabilitation etc.. These providers also manage most of the sheltered housing in their region.</p>

4. STAFF EMPLOYED IN MENTAL HEALTH SERVICES

Greece

In community settings provide services:

Adult and Child Psychiatrists, Psychologists, Nursing Staff, Social Workers, Mental Health Carers (not specialized staff, trained for everyday care of patients), Occupational therapists, speech therapists, vocational guidance experts, psychotherapists, drama therapists.

Italy

The involved vocational profiles in DSMs are:

5561 physicians (18.1%), 1850 psychologists (6.0%), 120 sociologists (0.4%), 171 psychiatric rehabilitation therapists (0.6%), 2095 educationists (6.8%), 1551 social workers (5.1%), 2698 + 1300 (13.0%) are generic care workers, 14.670 nurses (48%).

4.3 Latvia

In 2004, the proportion between the psychiatrists and nursing staff is 1:3,4), Other specialists (psychologist, social worker, ergo-therapist) involve in the work in episodes, more frequently in outpatient wards at psychiatric hospital because they have larger financial possibilities to involve additional specialists, as well as a possibility to involve in-patient specialists.

4.4 Scotland

Staff working in mental health field in Glasgow:

Social Work Departments: Mental Health Officers, Social workers ,Social care workers

NHS: GP (general practitioner), Psychiatrists , Community psychiatric nurses, Occupational therapists, Occupational therapist support worker, Health care assistants ,Psychologists, Counsellors ,Art therapists.

4.5 The Czech Republic

Roles and Functions:

Psychiatrists, Psychologists, Nurses, Social workers, Occupational therapists, Case manager.

Exact number of professions and professionals working in community services is not known (by our estimation majority of workers are social workers and occupational therapists).

There is no unified system of recruitment of new workers.

Each organization has own system

4.6 The Netherlands

The Dutch mental health care is staffed by 60.000 workers (46.000 fte), and this number is still growing. This means that there is 1 fte available for every 348 citizens, or 287 fte per 100.000 citizens.

There are 2.300 psychiatrists and 10.000 psychologists working, half of which are registered psychotherapists. We count over 15.000 psychiatric nurses, 6.000 social workers; 6.500 workers are 'lower' educated (social coaches etc.)

5. EDUCATION, TRAINING & UPDATING

5.1 Greece

- **Special Training** by Psychargos

- Psychargos project foresees special training for staff employed in the new community-based services.

These programs are organized by the services.

Funding: 75% by EU

- **MSU- Monitoring and Support Unit:**

- Organizes specialized 1 or 2 day training programs or workshops for professionals
- Monitors training needs of the professionals

- **Foreign exchanges**

- Activity of visiting advanced mental health services abroad (Italy, UK, France, Spain and Germany)
- Financed by the EU (75%) and the Ministry of Health (25%)

These activities :

- were part of the second phase of the Psychargos program
- at present these activities are not repeated

Developing and delivering ET&U, Continuing Education and Lifelong Learning

- No standardized procedures
- No written policy or strategy supporting and promoting
- Most programs don't take in consideration the actual needs of the professionals

Updating and Lifelong learning

- Only professionals' own initiatives

Teaching staff updating and effectiveness

- No established procedures for the training of trainers.

- Trainers have no teaching experience
- even though they may have great working experience
- **EPAPSY:**
- has established a pilot human resources development program :
- Internal to the firm
- Funded by the organization own means
- Planned to last for one year
 - The professionals don't receive any accreditation
 - Production of professional handbooks (guidance kit) for new employers

5.2 Italy

- Psychiatrists
- Psychologists
- Professional Nurses
- Other mental health professionals
 - Social workers
 - Rehabilitation therapists
 - Auxiliary and technical personnel (OTA, OS, etc.)
 - Educationists

Continuing Education and Lifelong Learning

- University and Colleges
- Acknowledged courses (at regional and local level)
- The ECM: Continuing Education in Medicine
 - All health workers are obliged to ECM
- Continuing education should include all educational activities that are pertinent to a person's professional skills, activities, interests, and growth.
- Continuing education can take many forms. In particular, a variety of programs are available that enable professionals and employers to improve their knowledge and skills while reducing their travel and

absence from the workplace.

- Each professional is expected to gain a total score of at least 150 credits over a 5-year time span.
- The credits are assigned by a central committee and reflect the time spent and the quality of the course.
- Moreover, the Commission has established criteria for the accreditation of educational initiatives, the verification of their quality, and the evaluation of the educational benefit participants have from them.
- The training firms are
 - scientific or professional associations,
 - health firms, like DSM, hospitals, etc.
 - NGOs
- They have the role and commitment to improving the quality of healthcare by providing all professionals with a better education and qualifications
- Many providers organize courses involving
 - “traditional” (classroom-based) techniques and
 - distance learning.
- 2 main course typologies:
 - In-company
 - Out-company
- Staff employed in NHRS have often low qualification level
- The ECM is often ineffective or “pro-forma”
- there’s not information about contents and efficacy of the Training and Updating programmes
- Supervision is lacking
- Shortage of vocational profiles with psycho-social competencies

5.3 Latvia

- **Vocational Education Centre of the Ministry of Education and Science:**

- promotes and coordinates training programmes to ensure the quality of educational services.

Normative documents have been drawn up in order to:

- harmonize the Latvian legislation with the EU directives
- enforce the EU medical education requirements

Certification of Medical Personnel

Ministry of Public Health ratifies the *Certification of Medical Personnel*:

- Job descriptions for medical personnel and minimum demands for the educational programme
- Mainly traditional (medical) approach based on psychiatrists and nurses
- In last years attempts to involve other specialists in the treatment and care
 - i.e., psychiatric nurses, social workers, ergo-therapists.
- After independency:
 - great effort to improve the personnel qualification
 - change of attitude towards patients (strengthening of knowledge about psychology, rehabilitation and ergo-therapy).

- **N/A**

At present N/A :

- Developing and delivering ET&U
- Community-based oriented ET&U
- Outing certifications and competencies
- Staff selection and vocational guidance

Continuing Education and Lifelong Learning

- The medical personnel that work in the system of mental health care is to update their professional certificate every 5 years.
- They must attend seminars and courses (in-house and others)

These seminars and courses are hold by:

- Psychiatry and Drug Abuse Treatment Department at the Riga Stradins University,
- Latvian Psychiatric Association
- other educational institutions

- **Latvian Association of Nurses**

The Latvian Association of Nurses developed a specialised psychiatric nurse study programme for nurse assistants working in psychiatry

5.4 Scotland

- **Scottish Social Services Council (SSSC)** is responsible for registering people who work in social services and regulating their education and training
 - Set up registers of key groups of social service workers
 - Publish Codes of Practice for all social service workers and their employers
 - Regulate the training and education of the workforce
 - Promote education and training
 - Undertake the functions of the Sector Skills Council
- The **SiSWE** (Scottish Executive's Framework for Social Work Education in Scotland) sets out the expectations of the Honours Degree in social Work.
- The **Social Work Training Rules 2003** set down the requirements which HEIs must meet in order to provide the honours degree.
- The **SCQF** (Scottish credit and qualification framework) assists learners, employers and the general public about qualifications.
- **NOS** (National Occupational Standards) are agreed statements of competence. NOS are the foundation on which Scottish Vocational Qualifications (SVQs) are developed.
- **NCS** (National Care Standards) describe what level of service an individual can expect from service providers.

- Matching Service Standards project ensure levels of practice meet specified standards by matching NOS against NCS
- The service standards guides include:
 - The guide for residential care of children and young people.
 - The guide for people with mental health problems.
 - The guide for older people in care homes

The Scottish Qualifications Authority

- **The Scottish Qualifications Authority (SQA)** is the national body responsible for the development, accreditation, assessment and certification of qualifications other than degrees.
- SQA manage the qualifications system below degree level
 - Devise, develop and validate qualifications and keep them under review
 - Accredite qualifications
 - Approve education and training establishments as being suitable for entering people for these qualifications
 - Arrange for, assist in, and carry out, the assessment of people taking SQA qualifications
 - Quality assure education and training establishments which offer SQA qualifications
 - Issue certificates to candidates.
 - Qualifications include:
 - National Qualifications
 - Higher National Certificates and Diplomas (HNC/HND)
 - Scottish Vocational Qualifications (SVQs)
 - Customised Awards and Professional Development Awards

Care Scotland

- It is a team of SQA staff dedicated to Social Care
- Within the "Care Sector" the following recognised training is available

- Health and Social Care Level 2
- Health and Social Care Level 3 (Adults)
- Health and Social Care Level 4 (Adults)
- Health and Social Care Additional SVQ Units
- Registered Manager in Health and Social Care Level 4
- Support Services in Health Care Level 2

Outing certifications and competencies

● National Occupational Standards

- presented as statements of competence
- formed into units, which describe the standards required for an area of work
- each unit separates out the activities undertaken by workers into elements that lay out the performance, knowledge and skills needed to demonstrate that the individual is competent and effective in this area.
- the standards can be used as the basis for qualifications (such as SVQs)

Scottish Vocational Qualifications

- SVQs are competence-based qualifications assessed in the workplace.
- They are nationally recognised qualifications at Levels 2, 3, 4 and 5, including SVQs in Health and Social Care and the Registered Manager Award and reflect the complexity and responsibility of different workers' roles

Staff selection

- Social care staff are employed by a variety of organisations.
- Informal carers provide a significant amount of care work.
- Partnership arrangements between organisations.
- Increased contracting out and commissioning of services.

Recruitment and retention

Department of Health's Survey

- Outcomes:
 - Profession's poor image
 - Stressful and difficult work
 - Inadequate funding
 - Poor pay and conditions
 - Unattractive terms and conditions of employment
 - Low status and lack of career progression
- **Needs:**
 - More flexibility
 - Better pay
 - Less demanding and stressful work
 - At present:
 - Increasing of a low paid and casualised workforce
 - Increasing of transient, temporary workers

High staff turnover

5.5 The Czech Republic

- Doctors (physicians): psychiatrists including child psychiatrists, psychotherapist, sexologists
- Other graduate professionals:
 - clinical psychologists, psychotherapists
 - speech therapist
 - physiotherapist
 - social workers
 - psychiatric nurses
 - special educationalists
- Professionals with a secondary school examination:

- social workers
 - registered nurses
 - physical therapists
 - occupational therapists
- Officially registered (obliged to a periodical re-registration and continual education):
 - Doctors, psychiatrists,
 - clinical psychologists, psychotherapists
 - nurses
 - No specific information available on number of personnel working in community based mental health care
 - Personnel in day activity centers, housing and vocational rehabilitation and support, case management stay mostly outside health care system (and statistics surveys).

Developing and delivering ET&U

- **Psychiatrist** have to participate in ongoing CE organized by licensed institutions
- Education is based on directives of the Czech Medical Chamber.
- **Clinical psychologists** and **psychotherapists** have to participate in ongoing CE, organized by licensed institutions.
 - Education is based on directives of the Association of clinical psychologists.
- **Social workers**
 - No continuous education for social workers is obliged.
 - Social workers working in a health care should participate in ongoing CE organizes by licensed institutions
 - Education is based on directives of the Czech Association of nurses
- **Occupational therapists** had undergone ongoing CE, organized by licensed institutions.

Community-based oriented ET&U and Lifelong Learning

- No special **Pre gradual education** in the field of community mental health care.
- Some bachelor programs have special courses like care, psychiatric rehabilitation for long term mentally ill (e.g. the South Bohemian University, Charles University, Department of Social care).

Post gradual education

- The National Centre of Attendance and Non-medical Health care Fields, the Postgraduate Medical Institute organize CE courses on some topics (not on a regular basis).
- The Charles University, Department of social work organizes The Course in a Community Care for long term mentally ill as a re-qualification course (150 hours);
- South Bohemian University prepares continual education for non-doctoral professions and social workers in community care.

NGOs

- NGOs organize many courses, which provide community care for mentally ill. They are approved by the Ministry of education as re-qualification courses and are focused on:
 - Community care in a general
 - Special course (case management, psychiatric rehabilitation etc.)
- Some NGO institutions organize courses on community care (in-company).
- Client organization VIDA provides client lectures implemented in pregradual and postgradual programs.

5.6 The Netherlands

- In the late nineties several efforts were made to simplify the professional system in the mental health care. Nowadays 5 groups of professionals:

1. Doctors (physicians): psychiatrist/psychotherapist,
 2. Psychologists: clinical psychologist/psychotherapist,
 3. Nurses: social psychiatric nurse, advanced nurse practitioners
 4. Social workers
 5. Therapists (psychomotor/creative)
- 1-4 are officially registered according to the Individual Professions Health Care Act (Wet BIG)
 - 1 and 2 are obliged to a periodical re-registration (permanent education)
 - In the future all professionals will be registered.

ET&U supply

- Universities: basic education and post-doc for 1 and 2
- Colleges: basic education and post-bachelor courses for 3
- NGOs: postgraduate courses for psychologists, clinical psychologists and psychotherapists
- Institutes for Intermediate Vocational Education (ROCs): basic education for nursing auxiliaries, all creative and psychomotor therapists
- Of all the workers in the Dutch mental health care only 11 % is low-educated (intermediate vocational education)
- All education institutes supply updating courses for their professionals (often to achieve a re-registration according to the law)
- In-company courses
- Exchange of professional experience
- Intervision and supervision

Community-based oriented ET&U, Continuing Education and Lifelong Learning

- Many of the updating courses (in Colleges and NGOs) are focused on community care:
 - case management
 - psychiatric home care
 - assertive community treatment

- More and more MHC-institutions ask for courses on community care (in-company)

Staff selection and vocational guidance

- Most selection procedures are rather strict
- Representatives of the client group/council are frequently involved in selection procedures.

Teaching staff updating and effectiveness

- The education institutes usually do not employ teachers
- Most teachers are professional care providers or researchers who work with clients themselves

Strong points

- Staff is highly educated and well motivated
- Most institutions stimulate permanent education of their staff
- Professional autonomy is strong

SWOT ANALYSIS

The **SWOT Analysis** (**S**= strengths; **W**= weaknesses; **O**= opportunities; **T**= threats) is currently one of the most widespread methodologies for evaluation of a wide typology of phenomena (e.g. aspects referring to context analysis). It is a logical procedure, derived from the business economy, which contributes to making gathered information more systematic, sharable and operative, in relation to a specific topic or subject. In this way it provides essential information to enable the definition of intervention plans through the analysis of alternative scenarios. More specifically, **endogenous** and **exogenous** factors are distinguished in the SWOT analysis. The terminology distinguishes between: the endogenous factors **S** and **W** (strong and weak points); the exogenous ones **O** and **T** (opportunities and threats).

The main objective of the analysis consists of describing the opportunities for improvement or development (**O**) within some studied aspects. Such **O** originate from enhancing **S** points and from managing and reducing the **W** ones in light of the **T** framework, which is usually derived from exogenous factors. The effectiveness of this surveying methodology above all depends on the ability to carry out "a cross sectional" reading of all the identified factors. In fact you have to lean upon the **S** points and to round off the defects (**W**) in order to maximize the **O** and to reduce the **T**.

In short, the SWOT analysis can be useful in order to:

- 1) Point out the main factors (internal and external to the context) able to influence the success of a training programme, project or intervention;
- 2) Identify and evaluate alternative developmental scenarios;
- 3) Foster the formulation of a coherent strategy with the referring contexts;
- 4) Outline the main strategic guidelines in relation to a general objective.

In our case, we asked the partners to carry out a SWOT analysis, using the data collected by desk analysis in the NRs, the researcher's expertise and their know-how. The analysis outcomes were displayed in a synthetic diagram and

afterwards described in more detail. This helped with the "cross sectional" reading.

SWOT diagram

Strong points	Weak points
...	...
...	...
Opportunities	Threats
...	...
...	...

This structure has been used by partners to summarise their results.

GREECE

• Strong points	• Weak points
<ul style="list-style-type: none"> • there are many community based services (most of all rehabilitation units) • deinstitutionalisation process in progress • some of the staff employed in the new community based services have specific training • Epapsy edited a handbook for mhcv (the book is in Greek) 	<ul style="list-style-type: none"> • standard of care in the community based services is not adequate • lack of user involvement • lack of expert trainers • most lifelong programs don't take into account the actual needs of professionals • lifelong learning is not compulsory (it depends on professional's personal initiatives)
• Opportunities	• Threats
<ul style="list-style-type: none"> • learn from the existing good practice regarding community based services • foster the role of users and their families • foster training exchanges to learn from foreign experiences • promote LIFELONG LEARNING • establish standard procedures to train the trainers • foster the deinstitutionalisation process 	<ul style="list-style-type: none"> • lack of laws and regulations for many agencies (particularly for NGOs) • funding is inadequate • lack of standard procedures for professional updating (in terms of continuing education) • lack of laws that promote lifelong learning

LATVIA

<ul style="list-style-type: none"> • Strong points 	<ul style="list-style-type: none"> • Weak points
<ul style="list-style-type: none"> • good mental health in-patient clinical base and vocational education for psychiatrists and nurses • understanding of the development of the service and the necessity of its reorganization by the personnel working in the mental health care system. • the government promotes and coordinates acknowledged training programs • guidelines were prepared to make the Latvian mental health system adequate to meet the EU standards • there is an existing post-degree course for psychiatric nurses 	<ul style="list-style-type: none"> • insufficient development of mental health community based services (especially the lack of networks to facilitate the patient's everyday life) • insufficient development of support networks in the community (insufficient involvement of society, mental health services users and their family members in the forming of the mental health care system) • insufficiently effective work of primary care specialists in the field of mental health care • insufficiently effective collaboration of mental health service with specialists from other spheres • disproportionate funding, insufficient for the provision of efficient mental health care • limited access to medicines for the treatment of mental diseases and disorders • limited human resources • lack of adequate legislation in the field of mental health • lack of professional training and updating programs concerning community based mental health
<ul style="list-style-type: none"> • Opportunities 	<ul style="list-style-type: none"> • Threats
<ul style="list-style-type: none"> • improve the traditional in-patient services and support their reorganization in accordance with EU policy • updating of educational programmes in compliance with evidence-based practices and service users' identified needs • promote COMMUNITY-BASED approach within the workforce and institutional and non-institutional STAKEHOLDERS • promote the participation and partnership of the mental health workforce in the transformation process 	<ul style="list-style-type: none"> • poor development of community-based mental health services, including the definition of the mission and functions of already operating institutions, as well as the design of the methodology of legal, financial and public relationships, with a special focus on out-patient services • lacks promotion of access to medicines; • lacks information about the community in order to build partnerships • lacks promotion of the development of human resources • lacks official support for a community based mental health approach • training programs are focused on traditional medical approach to mental health

CZECH REPUBLIC

<ul style="list-style-type: none"> • Strong points 	<ul style="list-style-type: none"> • Weak points
<ul style="list-style-type: none"> • existing examples of good practice of community based residential care • workers in already functioning community based mental health services are strongly oriented to support community living • psychiatrists (and other doctors), psychologists and nurses are obliged to certify LIFELONG LEARNING • there are organisations able to supply community based services • there are some specific training courses in community based approaches to mental health 	<ul style="list-style-type: none"> • shortage of COMMUNITY-BASED services • lack of trained staff in community based approach • lack of state policy promoting community based approach (lack of financial support system, lack of health and social system in residential care) • lack of adequate funding • there are not statistics on staff employed in community based services
<ul style="list-style-type: none"> • Opportunities 	<ul style="list-style-type: none"> • Threats
<ul style="list-style-type: none"> • strong need for residential care (estimated 2-3 thousand people from psychiatric hospitals) • support existing organizations which are able to provide residential services if provided with money • develop family and relatives movement and their lobbying • support policy oriented to community based care approach (community living) • promote community-based services in light of the starting of the deinstitutionalisation process, EU indications and evidence from scientific literature • extend lifelong learning to other mental health professionals • support training courses in community based mental health 	<ul style="list-style-type: none"> • lack of European incentive for policy aimed at increasing number of services • political interest/lobbying of big hospitals against de-institutionalisation and community based services • current state policy oriented to institutional mental health care • most of the available community based services are extraneous to the national health system (because they are lead by NGOs)

SCOTLAND

<ul style="list-style-type: none"> Strong points 	<ul style="list-style-type: none"> Weak points
<ul style="list-style-type: none"> existence of a well articulated system for training and updating of health and social care work-force User Involvement is widespread and well developed official recognition of social care model Plenty of examples of good practice New regulatory structures (SSSC) raising standards and competence existence of guidelines defining the occupational standards of workers and care standards of services presence of informal workers (volunteers) that deal with care 	<ul style="list-style-type: none"> Sometimes good practice is unacknowledged Limited resources available for service delivery combined with high expectations of commissioners about services that will be delivered within these resources affects relationship between commissioners and providers
<ul style="list-style-type: none"> Opportunities 	<ul style="list-style-type: none"> Threats
<ul style="list-style-type: none"> More opportunities for a "mixed market" across the voluntary, public and private sector Foster the change of focus to individual and corporate learning foster official acknowledgement of existing good practice that is still unacknowledged limit the process of driving down the qualitative standards of community based services supply raise the already existing occupational standards through the improvement of qualifications 	<ul style="list-style-type: none"> Competition (between providers) driving costs down which may impact on the calibre of available staff the training and accreditation system is very complex the employment conditions are unattractive for people high staff turn over increased temporary and occasional workers

NETHERLANDS

<ul style="list-style-type: none"> Strong points 	<ul style="list-style-type: none"> Weak points
<ul style="list-style-type: none"> In all catchment areas: mental health care is available for all citizens; almost all necessary kinds of treatment and care are available The mental health care system is rather accessible, although referral by a General Practitioner is formally needed Client participation has developed well; many (consumer run) facilities support clients in their attempts to survive within the community Although complex the financing system is good Registration of treatment and care is relatively good. Long term research about the mental health care situation of the population provides significant data Research on mental health (care) and support for MHC organisations and staff has developed well Staff are highly educated and well motivated Most institutions stimulate permanent education of their staff the system of professional training and updating is well organized there are lifelong learning certifications for doctors and psychologists Professional autonomy is strong staff are well trained and motivated many ngo organisations and other agencies ask for training courses focused on community based approaches in mental health 	<ul style="list-style-type: none"> The division between 'cure' (treatment) and 'care' within the system is unclear and threatens to complicate the system Risk of medicalisation (too many professionals?) Too slow development towards psychiatric community care Registration, control, staff meetings, quality systems etc. take more and more staff time at the expense of the available time for clients Although accessibility is rather good, the patient flow has blocked at many places within the system. Waiting lists for supported housing and specialised care are everywhere, despite or thanks to the relative richness of the system Graded system of care is often frustrated by waiting lists and bureaucracy
<ul style="list-style-type: none"> Opportunities 	<ul style="list-style-type: none"> Threats
<ul style="list-style-type: none"> extend lifelong learning to others professional categories involve users in training and staff selection promote separation between treatment (CURE) and care support and foster the transition towards community based models of care 	<ul style="list-style-type: none"> Separation between cure and care, especially for long term patients Adoption of alternative facilities within the MHC-system often leads to encapsulation; facilities have to adapt to new regulations (in order to get money) that may kill all creativity. Bureaucracy too complex

ITALY

<ul style="list-style-type: none"> Strong points 	<ul style="list-style-type: none"> Weak points
<ul style="list-style-type: none"> Normative (baseline?) that introduces explicit guidelines and aims to be achieved (relatives and users involvement, psycho-social rehabilitation, drop-out, suicide risk reduction, health promotion and prevention, fight against stigma) A well defined mental health system and subdivision of its competence on a regional level compulsory life-long learning for most of the vocational roles involved in the services. financial cuts could foster (in a paradoxical way) the development of community based services staff have very good experience in community based practice staff are generally well motivated 	<ul style="list-style-type: none"> Non homogeneous implementation of care at local level. The quality of care varies among regions and it depends on the local boards Financing cuts that could produce: Progressive reduction of workforce (financial cuts) Choice of low-cost care solutions, that could make the quality and intensity of care worse. Lack of well defined vocational paths professional paths not well defined and outdated low qualification level for a relevant part of the staff employed in community based services lack of professional courses with specific community based approach
<ul style="list-style-type: none"> Opportunities 	<ul style="list-style-type: none"> Threats
<ul style="list-style-type: none"> In a paradoxical way, financing cuts can be an opportunity: experience teaches that community-based services are cheaper than traditional medical services. So, financing cuts can provide a good occasion to develop new community services in place of the remaining old-style services Even with a lack of specific education, psychiatric workers have acquired a good praxis in working in community services. There is also a good level of motivation by them to acquire new instruments to improve their work. promote further diffusion of community based services in areas where the modernizing process was not accomplished effectively enough challenge the reinstituzionalization phenomenon by promoting a culture of a community based approach within the workforce foster the development of a "mixed market" across the voluntary, public and private sector improve the quality of care in light of 	<ul style="list-style-type: none"> Back to old institutionalized patterns Worsening of the quality of care Tendency to not define the mission of services well, confusing <i>cure</i> and <i>care</i> Life long learning is confused and not well monitored

evidence based practice

- promote separation between treatment (CURE) and care
- promote lifelong learning and extend it to the profiles of professionals not currently considered at all

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