Policy brief

Mental health II
Balancing institutional
and **community-based care**

by

David McDaid

Graham Thornicroft

European Observatory on Health Systems and Policies

Policy brief

Balancing institutional and community-based mental health care[1]

Introduction

Mental health care services across Europe may be provided in a number of settings: community, primary care, general hospital, specialist mental health institutions (such as high security or forensic psychiatry units) as well as in psychiatric hospitals. A key question that policy-makers and service-planners must face, therefore, is to determine what should be the balance in provision between these different services. Essentially, what is effective, what is cost-effective and what is feasible within different budgetary constraints?

The World Health Organization's *World Health Report 2001* called for a continued shift away from the use of psychiatric hospitals and long-stay institutions to the provision of community care, arguing that such care produces better outcomes, such as quality of life, that it better respects human rights and that it is more cost–effective than institutional treatment. The report recognized that community care implies providing a comprehensive range of services and points of contact, with contributions from different professionals and sufficient links to other sectors such as housing and employment (WHO, 2001a).

Certainly for much of the last century, long-stay psychiatric hospitals or asylums lay at the heart of mental health care in Europe. Historically they often had a strong emphasis on custodial care, limiting rights and paying little attention to rehabilitation. However, over the last 30 years major moves towards deinstitutionalization, that is, towards reducing the use of such institutions, have taken place in many European countries. These moves have not always been accompanied by the development of appropriate community and specialist care services, with the result that highly vulnerable individuals have not always received sufficient support. Indeed, the low priority attached by policy-makers

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1. This policy brief is one of a series on health care issues by the European Observatory on Health Systems and Policies. This series is available online at: www.observatory.dk

to mental health in some settings has meant that the closure of expensive long-stay institutions may be seen as an opportunity to reduce mental health budgets rather than to transfer resources to fund alternative community-based services.

The challenges are particularly great in central and eastern Europe, where resources for mental health are often very limited, and where psychiatric hospitals and long-stay social care homes (*internats*) continue to be the mainstay of mental-health service provision. In 2001, 17 countries in the European Region did not provide community-based mental health services; nearly all of these countries are located in central and eastern Europe, largely in the Balkans and the newly independent states of the former Soviet Union (WHO, 2001b). The pace of deinstitutionalization here has been slow, the stigmatization of mental illness is particularly marked, and the challenges of changing the balance of services are only now being faced.
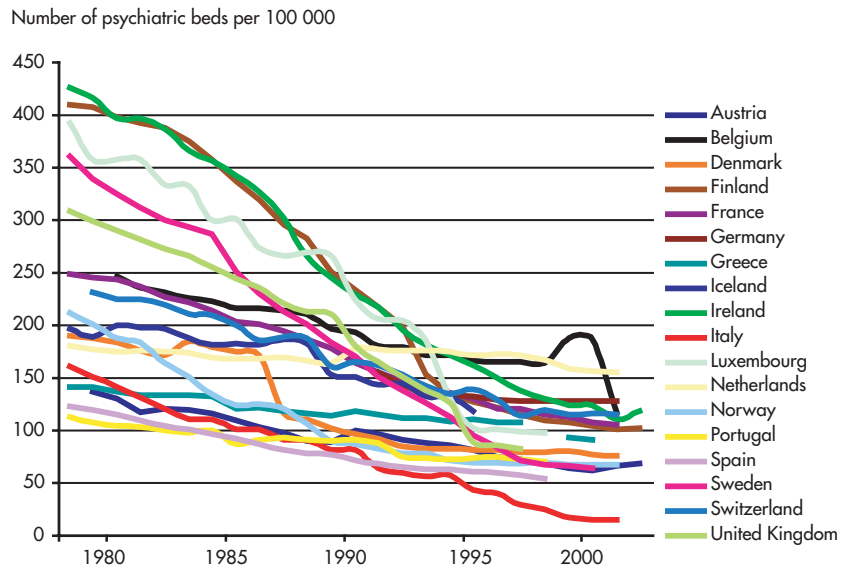
This policy brief provides an overview of the balance between institutional and community-based mental health care in Europe. It summarizes recent evidence on what should be the essential components of mental-health service provision based on evidence of effectiveness and cost–effectiveness. It also looks at how resource limitations may influence the development of the mix of services provided, and how economic barriers that may prevent financial resources being moved from institutional to community-based care might be overcome.

Trends in deinstitutionalization across Europe

The twentieth century was characterized first by the rise and then by the gradual reduction in the use of asylums as the mainstay of service provision for people with mental health problems in many parts of Europe. As the failings of the asylum system have become clearer, and as attitudes towards the protection of human rights have gained in importance since the 1950s, there has been a gradual shift by health policy-makers towards a policy of deinstitutionalization, that is, a reduction in the use of secluded, long-stay psychiatric hospitals. The costs of maintaining these expensive institutions and the availability of new medications have also undoubtedly had some influence on this process.

Over the last 30 years, in western Europe in particular, individuals have been transferred to other settings such as general hospitals or various forms of community-based supported living establishments, or have been returned to their family homes. Figure 1 illustrates trends in western Europe from 1978 (when Italy famously passed its law on deinstitutionalization) until 2002; in all

Figure 1: Trends in the numbers of psychiatric beds in western Europe, 1978–2002

Number of psychiatric beds per 100 000

Legend:
- Austria
- Belgium
- Denmark
- Finland
- France
- Germany
- Greece
- Iceland
- Ireland
- Italy
- Luxembourg
- Netherlands
- Norway
- Portugal
- Spain
- Sweden
- Switzerland
- United Kingdom

Source: European health for all database, WHO Regional Office for Europe, 2004.

countries bed numbers have fallen sharply; indeed in Italy there are relatively few psychiatric beds, while in Sweden there are now no specialized psychiatric hospitals in the country, all remaining beds being provided within general hospitals. Even countries with comparatively high numbers of psychiatric beds, such as Ireland and Finland, have substantially reduced bed numbers since the late 1970s.

Figure 2 illustrates that for the 10 new European Union Member States there has been significant progress in terms of deinstitutionalization over the last 15 years in Estonia, Lithuania and Cyprus in particular, but little change in other countries such as Slovakia and Slovenia (with very similar numbers of beds in 2002 to those in 1990). A downward trend is also observed in many countries from the former Soviet Union, although the Russian Federation still has the highest absolute number of inpatient psychiatric beds in the region, at just over 166 000.

Figure 2: Trends in the numbers of psychiatric beds in the new EU Member States, 1988–2002

Psychiatric beds per 100 000 population
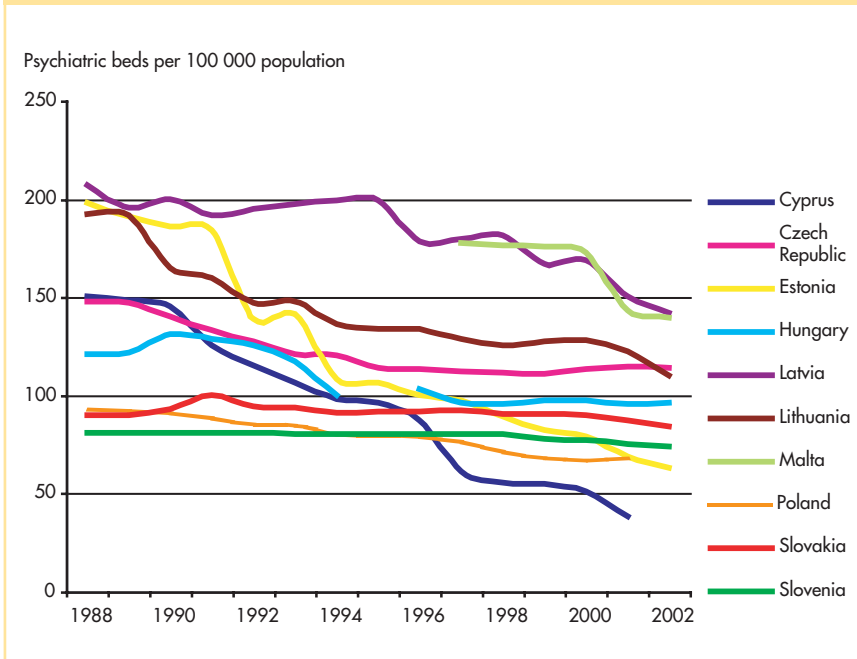
Source: European health for all database, WHO Regional Office for Europe, 2004.

The reliance of mental health systems on old-style institutional care has certainly been reduced in many countries, but caution must be exercised in interpreting these data. Obtaining accurate and comparable data on the actual number of psychiatric beds in psychiatric hospitals, general hospitals and other settings is difficult, and sometimes country estimates include beds that are not located in psychiatric hospitals. In particular, the provision of beds in social care homes in central and eastern Europe, which themselves have been accused of human-rights abuses, may not be included in these estimates.

Deinstitutionalization can also mean different things in different countries. In Germany, for instance, this process has included the transfer of individuals from psychiatric hospitals to redundant tuberculosis rehabilitation hospitals in the Black Forest, while, in Switzerland, it has referred to a reduction in the number of beds in existing psychiatric hospitals without any intention at policy level of moving psychiatry into general hospitals (Haug & Rossler, 1999).

Box 1: Key guiding principles for the organization of mental health services

Protection of human rights: Services should respect the autonomy of individuals and empower them to make decisions. The focus should be on the least restrictive treatments.

Accessibility: Services should be available locally; a lack of local services acts as a barrier to obtaining services, especially in rural areas.

Comprehensiveness: Services should include all facilities and programmes required to meet the needs of the population.

Coordination and continuity of care: Services should work in a coordinated manner to meet a range of social, psychological and medical care needs.

Effectiveness: Evidence of effectiveness should be used to develop services.

Equity: Access to services should be on the basis of need. Vulnerable individuals are less likely to demand services meeting their needs.

Efficiency: Evidence on cost–effectiveness should be taken into account in developing services and making decisions on resource allocation.

Source: Adapted from WHO, 2003.

What should the balance be between institutional and community-based care?

Each country must make its own decisions on the mix of mental health services that is necessary, taking into account a range of factors including population needs, level of resources, flexibility and coordination of organizational structures, as well as local culture. These factors should be an integral element of a national mental health policy and action plan, closely linked with national public health strategies (including mental health promotion).

Guiding principles
While the pattern of mental health services will vary between countries, a set of key guiding principles for their organization can be applied to all countries (see Box 1). Above all else, fundamental human rights should be respected regardless of whether services are based in the community or in hospital settings. It is also crucial to implement services on the basis of evidence of

effectiveness (where available), or at least to ensure that services are the subject of ongoing monitoring and evaluation. In terms of equity, services should be available right across a country and not just in urban centres, with utilization of services on the basis of need rather than the ability to pay. Efficiency is also important, for while decisions on the use of health care resources should never be made on grounds of cost–effectiveness alone, making use of cost–effectiveness can help to shift resources to interventions or services where they can best make a difference to improve health.

Review of the evidence

The extent to which services can be moved from institutions to the community and the appropriate model of care continue to be key questions for policy-makers. The mixed results of the deinstitutionalization process experienced by some countries may dissuade policy-makers from further moves towards community-based care. There might, of course, be a danger that justifiable concerns for the protection of human rights will lead to the end of all inpatient hospital and residential care. One recent attempt to address some of these issues has been the systematic review prepared for the Health Evidence Network of the WHO Regional Office for Europe (Thornicroft & Tansella, 2003 and 2004).

The key questions addressed by this review were:

1. *To what extent should mental health services be provided in community and/or hospital settings?*

2. *What service components are necessary and what are optional?*

3. *What are the differing service development priorities for areas (countries and regions) with low, medium and high levels of resources?*

4. *What are the arguments and evidence in the field?*

Overall, the review concluded that there are no persuasive arguments or data to support a hospital-only approach, nor is there any scientific evidence that community services alone can provide satisfactory comprehensive care. Instead, it argued that a "*balanced care*" approach is required, whereby front-line services are based in the community with back-up from hospitals, which provide a limited amount of acute inpatient care. Where hospital stays are required, they should be as brief as possible, with services provided in normal community settings rather than in remote, isolated locations. Not all elements of this balanced care approach are applicable or appropriate in each country.

Low-resource countries should focus on establishing and improving mental health services within primary care settings, using specialist services as a back-up.

Medium-resource countries should, in addition, seek to provide five core service components: (i) outpatient clinics, (ii) community mental health care teams, (iii) acute inpatient care, (iv) long-term community-based residential care, and (v) work and occupational care.

In addition to such measures, *high-resource countries* should provide forms of more differentiated care such as specialized ambulatory clinics and community mental health care teams, assertive community treatment, and alternatives to acute inpatient care, long-term community-based residential care, and evidence-based vocational rehabilitation.

Source: Thornicroft & Tansella, 2003.

Box 2 provides recommendations on the service mix depending on whether countries have a low, medium or high level of resources. Countries can extend the range and type of services required as resources permit.

Primary care

In all settings a range of mental health services can be provided through primary care facilities, backed up by access to specialists for training, consultation, inpatient assessment and specialist treatment. This link to specialists is of particular importance given that most mental health problems will be first seen in primary care, where the detection and management of common mental health problems such as depression remain poor. Effective training for primary care practitioners requires a combination of strategies, including access to information and liaison with and feedback from other health care professionals (Gilbody et al., 2004).

Mainstream mental health care

In countries with a medium level of resources or in low-income countries that are beginning to benefit from economic growth, additional mainstream mental health services can also be provided. These consist of:

(i) outpatient/ambulatory clinics,

(ii) community mental health teams,

(iii) acute inpatient care,

(iv) long-term community-based residential care, and

(v) work and occupational services.

Coordinating and delivering these services within geographical catchment areas can help to promote the principle of continuity of care, which involves identifying all the needs of an individual, taking into account not only their immediate health status but also their ability to live and function in their community. Using catchment areas may also reduce the risk that budgets for mental health services might become fragmented.

Additional *specialist care* in a situation of scarce resources in middle-income countries, such as those in most of central and eastern Europe, the review argues, should concentrate on supporting individuals with the most severe and long-term mental health problems. Disorders more often seen in primary care (such as depression) are more likely to decline over time without intervention. Outpatient clinics can be provided within primary care centres, mental health centres or in general hospitals.

Community mental health teams (CMHTs) provide a range of services (including the contributions of psychiatrists, community psychiatric nurses, social workers, psychologists and occupational therapists), and usually give priority to adults with severe problems. Such teams have been shown to improve the individual's engagement with services, to increase client satisfaction and improve concordance with treatment. They are also associated with improved continuity of care. At an individual level, *case management* can be used to coordinate a range of care and other services for an individual that will be provided by the CMHT.

Some *acute inpatient care* should also be provided to meet urgent needs, such as for people who may be suicidal; such care is often made available within general hospital settings. There is no hard-and-fast rule about the number of acute care beds that should be available. This will depend on local circumstances. Getting the balance right is also economically important: there are significant economic costs associated with the maintenance of acute inpatient care, which will reduce the level of resources available for all other community services.

Community-based alternative care arrangements can improve the quality of care and health outcomes while not raising costs. The TAPS (Team for the Assessment of Psychiatric Services) Programme looked, over a 15-year period,

Box 3: Assertive community treatment

Typical components:

- small caseloads (a team of about 10 core staff members assigned to about 100 patients);
- continuous services (operating 24 hours a day, 7 days a week);
- medication delivered by team members daily if necessary;
- potential for service users to graduate to less intensive interventions;
- team approach, drawing on the contributions of psychiatrists, nurses and other professionals;
- service-user finances arranged or directly managed by the team;
- target for 80% of team activity to take place in the community.

Does it work?

- For people with severe psychotic disorders, assertive community treatment can reduce hospital admissions and acute inpatient days, but overall it does not reduce costs.
- It contributes to improvements in living arrangements and work status.
- It improves service-user satisfaction.
- It may offer fewer advantages if existing services already provide high-quality continuity of care.

Source: Thornicroft & Tansella, 2003

at the cost and quality of care and the health outcomes for 751 long-stay patients (mean length of stay 17 years) discharged into the community (mostly into staffed residential homes) from two psychiatric hospitals in England. Each individual was followed up and interviewed one year after leaving hospital and again five years later. Of the 523 individuals who were still alive at the time of the five-year follow-up, nearly 90% were still living in the community, with few individuals having come into contact with the criminal-justice system or become homeless. At least one third of all individuals had been readmitted to hospital at least once, leading the authors to suggest that 9 or 10 beds should be available for every 100 people discharged into the community, some of which could be in rehabilitation units (Trieman et al., 1999).

Specialized mental health services

High resource countries, such as those in western Europe, as part of a comprehensive system of care, can provide *highly specialized services*, for instance for people with eating disorders or a dual diagnosis of a mental health and a substance abuse problem. More alternatives to acute inpatient treatment, such as home treatment or crisis resolution teams, may also be provided. Early intervention teams (although evidence of their effectiveness remains inconclusive) and *assertive community treatment* (ACT) teams might operate (see Box 3). A greater range of residential accommodation would be provided, ranging from intensive to sheltered and independent living arrangements. Dedicated vocational rehabilitation schemes, including sheltered workshops and job placement schemes, may be provided, as the ability to work has been shown to have a significant impact on quality of life and self-esteem. While there are many different types of vocational rehabilitation, schemes that place people in real jobs and then provide support and training ("place and train") are more effective in helping them to gain and maintain employment than "train and place" schemes, which provide pre-vocational training (Marshall et al., 2001). From a broad perspective, effective vocational rehabilitation is clearly of advantage to the economy if individuals can support themselves and pay taxes rather than having to survive on disability or unem-ployment benefits.

Is community care cost–effective?

Evidence on the cost–effectiveness of community care versus institutional care suggests that community-based services do not necessarily reduce health system costs, but that the quality of life and satisfaction with services are improved, while the costs remain broadly the same. There is also evidence that quality of care is closely related to expenditure on services. One randomized controlled trial looking at the costs of moving from hospital-based to community-based services offering problem-oriented, home-based care, found that the community programme was significantly less costly in the short to medium term (Knapp et al., 1995). The TAPS study in England reported that the costs of community care for those individuals discharged into the community earliest were lower than those of hospital care, while, in Australia, a study conducted following the closure of a psychiatric hospital in Sydney also reported lower costs but noted that existing community service provision was sufficient to cater for these additional service users, avoiding the costs of service expansion (Lapsley et al., 2000).

Reviews of economic evidence on assertive community treatment suggest that such treatment does not have a systematic impact on the overall costs of care,

but that it is associated with improved quality of life and satisfaction, as rated by the service user, suggesting that such treatment can be cost–effective, although the evidence on the cost–effectiveness of home treatment teams remains to be established (Burns et al., 2001). Acute day hospitals that provide intensive psychiatric care without the high overheads and restrictions on liberty may also be a cost–effective alternative to inpatient care when demand for inpatient beds is high (Marshall et al., 2001).

What are the economic barriers to changing the balance of service provision?

There are a number of financial and economic barriers that can hinder shifting the balance in the provision of services away from a historical focus on institutional-based care to community-orientated care (Knapp et al., 2004). Financial resource- allocation systems in low- and middle-income countries in the central and eastern part of the European Region may still link funding for mental health services directly to psychiatric hospital bed occupancy, allowing little flexibility and providing little incentive for local planners to develop community-based alternative services. This resource-allocation system can be exacerbated by perverse funding formulae: in the Russian Federation, for instance, psychiatric hospitals with more than 1000 beds occupied can be more generously financed than smaller hospitals (Samyshkin et al., 2004).

Even in countries where deinstitutionalization is taking place, there remains a danger that funds will not be transferred to the provision of community-based services, as there may be a false perception that fewer resources are required to provide community-based care. Decision-makers may thus see the closure of institutions as an opportunity to reduce the budget for mental health and to spend the released funds in quite different areas. For instance, Hungary has seen a 50% decline in the number of beds in mental hospitals with apparently little development of community services (Harangozò & Kristòf, 2000). Protection of the mental health budget can help to ensure that resources are actually transferred to alternative community services. The closure of long-stay institutions and social care homes might also be encouraged by moving to a per capita funding system whereby funding follows an individual regardless of where they receive services. Political will is vital to the introduction of such changes.

The need to ensure that there is an adequate level of funding to provide a range of mental health services is not restricted to low- and middle-income countries; mental health historically has been a low priority for policy-makers right across Europe. Resource allocation formulas that take mental health

needs into account can be used to set budgets in tax-based systems, while reimbursement rates in social health-insurance systems need to be calculated accurately to fully cover the costs of mental health problems.

Making decision-makers aware of the cost implications of their decisions can also be quite illuminating; making them financially responsible in a direct way can be influential in changing behaviour. The re-routing of funding in both England and Australia to pay for inpatient psychiatric treatment, so that it was no longer passed as a block grant from a central authority to hospital managers but was instead transferred to local health agencies, which then had to purchase inpatient care for those of their local residents accommodated as inpatients, provided very clear signals of the real costs of treatment. Local decision-makers began to ask whether it might not be possible to provide support more cost–effectively in other settings, such as in the community.

Parallel funding

Changing the balance of service provision is not just a question of transferring some existing resources to community services. There is usually a need to invest in new physical capital and human resources in the community prior to the closure of a hospital, to ensure the smooth and effective movement from one system to another. During this transitional period, funding is required for both existing institutions and new services. Failure to provide such additional funding can lead to problems in successful implementation of changes in the service mix, as has been seen at different times in, for instance, Denmark, Italy and in England, which may heighten calls for an end to the deinstitutionalization process. For a vulnerable group of people with severe mental health problems, this can be problematic, leading to poverty, homelessness, social exclusion, violence and contact with the criminal-justice system. Lack of funding is only one of the barriers to reform, and official attitudes may also need to change; Luxembourg, despite its high level of expenditure on mental health (13% of the health budget), has been late in developing community-based care (Haug & Rossler, 1999).

Conclusion

Over the last three decades significant efforts have been made in many European countries to move away from a mental health system dominated by institutional care alone towards one whereby the main emphasis is on providing care and support within the community. The evidence supports the validity of developing a balance between community and hospital services in all countries regardless of resources. In low-income countries, primary care should lie at the heart of mental health treatment, supported by access to some

specialist services. In middle-income countries, a greater range of core mental health services can be provided, including both community mental health teams and acute inpatient care, while comprehensive services in high-income countries can include highly specialist services, the use of specialist assertive community mental health teams, a variety of community-based residential care services and work/rehabilitation services that can help individuals to gain and maintain employment. The evidence on the cost–effectiveness of these services is broadly positive, with many services seen to be associated with improved health and quality of life outcomes, with costs often no higher than in institutional-based alternative services.

Some studies have suggested that deinsitutionalization has not worked. This usually reflects a lack of effective implementation of community-based services. Developing these services and providing sufficient resources to sustain them are critical, as are effective coordination with other sectors, such as social care, housing and employment, and collaboration with consumer and family groups. The needs of the mental health workforce should also not be overlooked when considering the balance of services. A well-trained workforce is a prerequisite for quality services. Training should not be restricted to mental health-related skills alone; there is also a need for training in organizational and managerial skills, which in particular are lacking in some countries, hampering reform and the coordination of multiagency, multisectoral services.

Finally, it is also necessary to put in place systems that help to strengthen the evidence base on what works and in what context; we still have no information on either the effectiveness or the cost–effectiveness of many interventions and methods of delivering services. The use of case registers of individual service users can be helpful in monitoring both the use of services and their long-term outcomes.[2]

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Balancing institutional and community-based care

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More information on mental health in Europe can be found in:

Mental health policy and practice across Europe

Edited by Martin Knapp, David McDaid, Elias Mossialos and Graham Thornicroft

Contents

Balancing institutional and community-based care

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This policy brief is intended for policy-makers and those addressing the issues of mental health and health care systems.