OFÍCIO Nº 657/2019/ASPAR/GM/MS

Brasília, 04 de abril de 2019.

A Sua Excelência a Senhora
Deputada SORAYA SANTOS
Primeira-Secretária
Edifício Principal, sala 27
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Senhora Primeira-Secretária,

Reporto-me ao expediente destacado na epígrafe, referente ao Requerimento de Informação nº 103, de 28 de fevereiro de 2019, para encaminhar as informações prestadas pelo órgão técnico deste Ministério.

Atenciosamente,

LUIZ HENRIQUE MANDETTA
Ministro de Estado da Saúde

Ministério da Saúde
Secretaria de Atenção à Saúde
Gabinete da Secretaria de Atenção á Saúde

Parecer

DESPACHO

SAS/GAB/SAS/MS

Brasília, 28 de fevereiro de 2019.

RESTITUA-SE à Assessoria Parlamentar - ASPAR/GM/MS, para conhecimento e providências relativas ao Despacho CGMAD/DAPES/SAS/MS - 8142897 e seus anexos 8145271, 8145311, 8145352, 8145384, 8145407, 8145439 e 8145454, elaborado pelo Departamento de Ações Programáticas Estratégicas, desta Secretaria, em atendimento ao Despacho ASPAR/GM/MS.

FRANCISCO DE ASSIS FIGUEIREDO
Secretário de Atenção à Saúde

Documento assinado eletronicamente por **Francisco de Assis Figueiredo, Secretário(a) de Atenção à Saúde**, em 12/03/2019, às 18:58, conforme horário oficial de Brasília, com fundamento no art. 6º, § 1º, do Decreto nº 8.539, de 8 de outubro de 2015; e art. 8º, da Portaria nº 900 de 31 de Março de 2017.

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Ministério da Saúde
Secretaria de Atenção à Saúde
Departamento de Ações Programáticas Estratégicas
Coordenação-Geral de Saúde Mental, Álcool e Outras Drogas

DESPACHO

CGMAD/DAPES/SAS/MS

Brasília, 26 de fevereiro de 2019.

REF.: Requerimento de informações S/N de 2019

INT.: Partido Socialista e Liberal - PSOL

ASS.: informações acerca da nota técnica nº 11/2019.

1. Trata-se do Requerimento de informações da Bancada do PSOL na Câmara dos Deputados, na qual solicita ao Ministro da Saúde, Sr. Luiz Henrique Mandetta, informações acerca da nota técnica nº 11/2019, publicada pela Coordenação Geral de Saúde Mental, Álcool e Outras Drogas e a "Nova Saúde Mental" anunciada pelos gestores do Ministério.

2. Atendendo ao solicitado segue:

3. Quantas e quais exonerações ocorreram na Coordenação do Sr. Quirino Cordeiro Júnior desde sua nomeação? Houve algum parâmetro "ideológico" que balizaram essas exonerações? A defesa da Lei nº 10.216/2001 e da Reforma Psiquiátrica no Brasil foi considerado critério "ideológico" para essas exonerações?

Resposta: Desde a nomeação do Sr. Quirino Cordeiro Junior, não houve exoneração na Coordenação-Geral de Saúde Mental, Álcool e Outras Drogas. Ressalta-se que este Ministério da Saúde não usa parâmetros "ideológicos" para balizar qualquer atividade administrativa.

4. O documento afirma que o objetivo é "fazer com que pacientes tenham acesso a tratamento efetivo no SUS (...) sem deixar de lado nenhuma modalidade de tratamento validada e aplicável. " Quem deve validar as modalidades de tratamento da "Nova Saúde Mental"? O que é considerado "aplicável" nesse processo de validação?

Resposta: Importante reforçar que o documento não representa uma "Nova Saúde Mental" da atual gestão do Ministério da Saúde. Portanto, a política atual continua regida pela Resolução CIT 32 de 14 de dezembro de 2017 e pela Portaria nº 3.588 de 21 de dezembro de 2017.

5. Quais motivos ensejam a inserção do Hospital Psiquiátrico e das Comunidades Terapêuticas como pontos de atenção da Rede de Atenção Psicossocial (RAPS)?

Resposta: As comunidades terapêuticas tiveram origem como `serviços de atenção em regime residencial, de caráter transitório´, desde 2011, compondo a Rede de Atenção Psicossocial (RAPS). Portanto, não foram inseridas em 2017, mas em 2011. Segue trecho da Portaria nº 3.088, de 23 de dezembro de 2011, que constituiu a RAPS:

> Art. 9º São pontos de atenção na Rede de Atenção Psicossocial na atenção residencial de caráter transitório os seguintes serviços:
>
> II - Serviços de Atenção em Regime Residencial, entre os quais Comunidades Terapêuticas: serviço de saúde destinado a oferecer cuidados contínuos de saúde, de caráter residencial transitório por até nove meses para adultos com necessidades clínicas estáveis decorrentes do uso de crack, álcool e outras drogas. (Grifo nosso)

Cita-se ainda a Portaria nº 131, de 26 de janeiro de 2012, que "institui incentivo financeiro de custeio destinado aos Estados, Municípios e ao Distrito Federal para apoio ao custeio de Serviços de Atenção em Regime Residencial, incluídas as Comunidades Terapêuticas, voltados para pessoas com necessidades decorrentes do uso de álcool, crack e outras drogas, no âmbito da Rede de Atenção Psicossocial", hoje disposta na Portaria de Consolidação nº 6 de 28 de setembro de 2017, Anexo XCI, Capitulo I, art. 1º ao 24º. Quanto aos hospitais psiquiátricos, nunca deixaram de existir e de prestar serviços à população. São unidades financiadas com recursos do SUS, nas três instâncias de gestão, funcionando como retaguarda para estados e municípios, e tendo seu papel reconhecido pela Comissão Intergestores Tripartite – CIT do SUS.

6. Que tipo de regulamentação e normas de fiscalização das Comunidades Terapêuticas a atual gestão do Ministério propõe?

Resposta: As Comunidades Terapêuticas são regulamentadas pela Resolução Conad 01/2015, onde estão elencados os critérios e as competências para fiscalização. Para tanto, foi criado um grupo de trabalho interministerial, com membros dos Ministérios da Saúde, Justiça, Trabalho e Desenvolvimento Social, para estabelecer critérios para o funcionamento, monitoramento, expansão e financiamento desses serviços (Portaria Interministerial nº 2, de 21 de dezembro de 2017).

7. O documento introduz a ideia do CAPS IV AD, como uma nova modalidade para a abordagem das pessoas com "uso nocivo de drogas e dependência de substâncias psicoativas" "promovendo o atendimento mais próximo do cidadão". Para tal, os CAPS IV AD funcionarão 24 horas nas "regiões das cracolândias" com o intuito de atender as emergências psiquiátricas, encaminhando-os para outros serviços da rede ou absorvendo-os no próprio CAPS AD. Afinal, quais evidências sustentam a criação de CAPS AD IV que dispensam os outros serviços existentes ou mesmo concorre com eles?

Resposta: O CAPS IV foi instituído pela Portaria GM/MS 3.588/2017. São unidades voltadas ao pronto atendimento de pessoas com problemas graves relacionados ao uso e dependência de substâncias psicoativas. Não se sobrepõem, mas ocupam uma lacuna. Não dispensam a existência da rede ambulatorial, de CAPS, de proteção social. Há evidências de que o mau atendimento às urgências e emergências e a falta de retaguarda especializada aumentam a morbidade e mortalidade e é nesse ponto que o Ministério se propõe a agir, sem nenhum prejuízo aos demais serviços.

8. À luz da Portaria nº. 3.588, de 21 de dezembro de 2017, o Ministério afirma que abandonará as políticas de redução de danos e retomará a lógica da abstinência, por meio de Comunidades Terapêuticas e Hospitais Psiquiátricos?

Resposta: Não há nenhuma afirmação nessa lógica inserida na Portaria 3.588/2017. Trata-se de um equívoco de interpretação. As abordagens devem ser plurais e centradas nas necessidades do sujeito. O que ocorria era o uso da redução de danos como uma finalidade em si. A redução de danos é uma das ferramentas terapêuticas e está mantida. Não se trata da única resposta e da única abordagem possível. O direito à saúde é garantido pela Constituição Brasileira e não pode ser condicionado apenas à abstinência de substancias psicoativas:

> *Art. 196. A saúde é direito de todos e dever do Estado, garantido mediante políticas sociais e econômicas que visem à redução do risco de doença e de outros agravos e ao acesso*

universal e igualitário às ações e serviços para sua promoção, proteção e recuperação.

Portanto, o Ministério da Saúde não considera que a abstinência seja o único objetivo a ser alcançado na abordagem de pessoas com uso prejudicial de substancias psicoativas, na medida em que esse comportamento não pode limitar o direito de acesso ao sistema de saúde.

9. Quanto à internação de crianças e adolescentes, prevista expressamente no texto da Nota Técnica, "(...) a melhor prática indica a necessidade de que tais internações ocorram em Enfermarias Especializadas em Infância e Adolescência. No entanto, exceções à regra podem ocorrer, sempre em benefício dos pacientes " (P. 24). Assim, para essa modalidade de internação prevista na Nota Técnica, qual é o embasamento jurídico? Qual norma jurídica sustenta o acompanhamento da população adulta e infanto-juvenil no mesmo espaço? O Ministério da Saúde estimulará modalidades de internação que confrontam a legislação existente?

Resposta: O Estatuto da Criança e do Adolescente (ECA) prevê a internação enquanto medida protetiva de caráter específico, determinada por autoridade competente com objetivo de "requisição de tratamento médico, psicológico ou psiquiátrico, em regime hospitalar ou ambulatorial" (inciso V, art. 101, ECA). A legislação em vigor no SUS prevê a implantação de serviço hospitalar de referência em saúde mental com "leitos de pediatria qualificados". Documentos técnicos publicados pelo Ministério da Saúde, a exemplo do instrutivo "Atenção psicossocial a crianças e adolescentes no SUS", orientam que crianças e adolescentes, em caso de necessidade, podem ser acolhidos nos leitos disponíveis, mesmo que não existam no território leitos específicos para crianças e adolescentes. No entanto, essa abordagem terapêutica deve ser pontual, "articulada com o projeto terapêutico singular desenvolvido pelo serviço de referência do usuário (como o CAPS ou uma unidade básica de saúde) e a internação deve ser de curta ou curtíssima duração". (Brasil, 2014: p.38). A legislação vigente citada pode ser consultada na Portaria de Consolidação nº 3, de 28 de setembro de 2017, Anexo V, Capitulo II, Titulo III, art. 51 ao 63 (Portaria de origem 148/2012).

10. A Nota afirma que "(...) o atendimento Ambulatorial também passa a ser incentivado. (P. 4) E o atendimento ambulatorial deverá "ocupar um vazio assistencial que existia na RAPS" (P. 2). No entanto, outros dispositivos da rede de assistência como CAPS, NASF e Atenção Básica vêm sofrendo desfinanciamento. Assim, se o Ministério financiará a abertura do atendimento ambulatorial, o problema apresentado até então para a RAPS existente (ausência de recursos financeiros) parece não se apresentar. Como, então, o Ministério vai financiar esses outros dispositivos, especialmente o atendimento ambulatorial, uma vez que os recursos para implementação de outros serviços da rede, como o CAPS, têm sido cortados?

Resposta: Quanto ao financiamento não houve cortes na implantação de serviços da Rede de Atenção Psicossocial e não há cortes previstos em 2019. Destacamos que a partir do ano 2014 o Ministério da Saúde passou a receber as propostas por meio do Sistema de Apoio à Implementação de Políticas de Saúde - SAIPS, é um sistema aberto para Rede de Atenção Psicossocial – RAPS, o sistema tem o objetivo de aperfeiçoar as solicitações de transferências de recursos financeiros ou credenciamento/habilitação de serviços necessários à implantação de políticas em saúde; permitindo transparência, agilidade, organização e monitoramento das solicitações. A ferramenta foi desenvolvida para facilitar e agilizar os pedidos de recursos feito por gestores Municipais, Estaduais ou do Distrito Federal para custeio, implantação, habilitação ou credenciamento de equipes, unidades e serviços em saúde.

11. Ainda sobre os valores apresentados como adicional para expandir e qualificar a RAPS, qual é o cálculo, incluindo seus componentes, para o incentivo de custeio aos leitos psiquiátricos em Unidade de Referência Especializada em Hospital Geral e também em Hospitais Psiquiátricos? Como esse incentivo se coaduna com a Lei da Reforma Psiquiátrica, que prevê a desinstitucionalização?

Resposta: O Ministério da Saúde não pretende implantar leitos psiquiátricos, assim como nenhum outro tipo de leito em hospital especializado em psiquiatria. Vale ressaltar que a

desinstitucionalização dos pacientes moradores de hospitais psiquiátricos continua sendo incentivada pelo Ministério da Saúde que não entende esses serviços como locais de moradia de pacientes. A Resolução nº 32 aprovada pela Comissão Intergestores Tripartite (CIT) em 2017, reforça o compromisso de apoiar técnica e financeiramente o processo de desinstitucionalização de pacientes moradores em Hospitais Psiquiátricos (Art. 8º), veda "qualquer ampliação do número de leitos por hospitais psiquiátricos" (Art. 10º) e determina o redirecionamento de recursos oriundos do fechamento dos leitos de hospitais psiquiátricos "para outras ações em saúde mental no respectivo Estado" (§ único).

12. Qual foi o efetivo custeio empenhado aos serviços que compõem a RAPS no período de 2014 a 2018? Solicitamos que os valores sejam especificados por tipo de serviço e fonte de custeio.

Resposta: Os dados solicitados são de domínio público e podem ser acessados por ano no Relatório de Gestão da Secretária de Atenção à Saúde por meio do site: http://portalms.saude.gov.br/relatorio-de-gestao

13. Para justificar a manutenção de vagas em leitos psiquiátricos, mesmo após a desinstitucionalização de "moradores", a Nota argumenta que a cobertura desta modalidade assistencial é deficitária, uma vez que atualmente existem 0,1 leito por 1000 habitantes e a Portaria nº 3.088/2011, usando como referência o postulado pela Portaria GM/MS 1101/2002, define a necessidade de 0,45 leitos por 1000 habitantes. De onde foram retirados tais dados? A manutenção dessas vagas não contraria o que está disposto na Lei n. 10.216/2001, que coloca a internação como última possibilidade? Se não ocorre o fechamento do leito, como garantir o fortalecimento dos serviços que promovem o cuidado em liberdade?

Resposta: A pergunta traz em si sua resposta: os indicadores são os dispostos nas portarias supracitadas. Que houve encontram-se dispostas na Portaria de Consolidação nº 3, de 28 de setembro de 2017 e Portaria de Consolidação nº 6, de 28 de setembro de 2017. A Portaria GM/MS nº 3.588/2017 dispõe expressamente que não haveria expansão dos leitos em hospitais psiquiátricos. Porém, não se fala do fechamento dos leitos remanescentes. O Ministério da Saúde permanece incentivando a implantação de unidades em hospitais gerais. Somos absolutamente contrários a qualquer serviço de má qualidade, seja CAPS, leito em hospital geral ou hospital psiquiátrico.

14. Um dos pontos da Nova Política Nacional de Saúde Mental é a expansão dos Serviços Residenciais Terapêuticos (SRTs), equipamentos voltados à reinserção social dos pacientes e fundamentais para a desinstitucionalização dos que moram em hospitais psiquiátricos. Nas novas ações do Ministério da Saúde, as SRTs também passam a acolher pacientes com transtornos mentais em outras situações de vulnerabilidade, como por exemplo, aqueles que vivem nas ruas e também os que são egressos de unidades prisionais comuns." (P. 4). Com a ampliação do perfil dos SRTs (residências terapêuticas), quais serão os critérios para inclusão nesses dispositivos? As pessoas internadas ininterruptamente há mais de dois anos, conforme a Lei n. 10.708/2003, deixarão de ser prioridade no processo de desinstitucionalização?As residências terapêuticas deverão absorver as crianças e adolescentes autistas? Como será o convívio familiar? Essa inserção não contraria o direito ao convívio comunitário e familiar estabelecido no Estatuto da Criança e do Adolescente? Essa inserção não contraria o direito ao convívio comunitário e familiar estabelecido no Estatuto da Criança e do Adolescente?

Resposta: Os serviços são de gestão dos municípios e estados. Estes entes devem definir seus critérios e prioridades, de acordo com suas necessidades. Estimulamos a participação mais direta

dos estados, inclusive no cofinanciamento e implantação de unidades. O respeito ao regramento legal é um pressuposto. As prioridades, a nosso ver, devem seguir critério clínico e social. Os critérios adotados devem ser pautados pela legislação vigente, ou seja, na Portaria de Consolidação nº 3 de 28 de setembro de 2017, Anexo V, Titulo V art. 77 ao 91 e Portaria de Consolidação nº 6 de 28 de setembro de 2017, Capitulo III, seção VI, art. 1027 a 1030 e a Portaria nº 3.588 de 21 de dezembro de 2017.

Resposta: Quanto ao Processo de Desistitucionalização ela não deixará de ser prioridade. A que se destacar que continuam em vigor as diretrizes de desinstitucionalização e mudança do modelo assistencial definidas desde 2001 pela Lei da Reforma Psiquiátrica (LF 10.2016/2001), segunda a qual é "vedada a internação de pacientes portadores de transtornos mentais em instituições com características asilares (Art. 3º, § 3º); o tratamento deverá ser, "preferencialmente, em serviços comunitários de saúde mental" (Art. 2 – IV) e a internação "só será indicada quando os recursos extra-hospitalares se mostrarem insuficientes" (Art. 4º).

As residências terapêuticas deverão absorver as crianças e adolescentes autistas? Como será o convívio familiar? Essa inserção não contraria o direito ao convívio comunitário e familiar estabelecido no Estatuto da Criança e do Adolescente? Essa inserção não contraria o direito ao convívio comunitário e familiar estabelecido no Estatuto da Criança e do Adolescente?

Resposta: Quanto ao direito ao convívio comunitário e familiar estabelecido no ECA, a que se esclarecer o conceito de Serviço de Residencia Terapêutica, entende-se como Serviços Residenciais Terapêuticos (SRT) moradias inseridas na comunidade, destinadas a cuidar dos portadores de transtornos mentais crônicos com necessidade de cuidados de longa permanência, prioritariamente egressos de internações psiquiátricas e de hospitais de custódia, **que não possuam suporte financeiro, social e/ou laços familiares que permitam outra forma de reinserção.** (grifo nosso)

15. A Coordenação Saúde Mental, Álcool e Outras Drogas afirma que "as ações foram construídas conjuntamente entre os gestores do SUS e cerca de 70 entidades, todas conhecedoras da realidade da saúde mental no país." (P. 3). Todavia, chegou até a Bancada do PSOL a informação de que, desde 2017, nem mesmo as entidades da sociedade civil que compõem o Conselho Nacional de Saúde têm sido consultadas para debater as mudanças impostas pelo Ministério da Saúde na área da saúde mental. Neste sentido, há quase três anos a participação social tem sido praticamente negada pelos órgãos estatais, o que tem prejudicado sobremaneira a implementação adequada da RAPS. Portanto, quais são de fato as 70 entidades ditas conhecedoras da realidade da saúde mental no país que participaram dessa construção, como foram convidadas para esse processo e como se deu a sua participação?E ainda, quem são os membros do Comitê Gestor Interministerial criado para estabelecer critérios para o funcionamento, expansão e financiamento desses serviços (Portaria Interministerial n.º 2, de 21 de dezembro de 2017)? Solicitamos a ata das reuniões, cronograma, plano de trabalho e relatórios preconizados no art. 8º da referida Portaria.

Resposta: As discussões ocorreram em dezembro de 2017, em Comissão Intergestores Tripartite (CIT), que reúne o Ministério da Saúde e representantes estados (CONASS) e municípios (CONASEMS), resultando na (Resolução CIT No. 32/2017 e Portaria No. 3.588/2017). O número de entidades citadas na nota, são de apoio as alterações na politica e podem ser visualizadas a partir do site: https://m.facebook.com/apoioanovaraps/?locale2=pt_BR. Quanto a Portaria que instituiu o comitê Gestor Interministerial, tendo em vista a reorganização da Coordenação Geral de Saúde Mental Álcool e Outras Drogas, aguardamos a nomeação do Coordenador Geral de Saúde Mental Álcool e Outras Drogas, para dar andamento em seus efeitos.

16. Quais são os critérios e o fluxo estabelecidos pelo Ministério da Saúde para a

prática de Eletroconvulsoterapia (ECT)? Solicitamos a lista atualizada de estabelecimentos no país que estão habilitados para realizar o procedimento de ECT e respectiva quantidade de execuções no ano de 2018 (execuções totais e por paciente). O Ministério pretende ampliar o financiamento da ECT? Quais são os estudos em saúde mental que justificam a medida?

Resposta: A eletroconvulsoterapia (ECT) não consta da tabela de procedimentos do SUS, nem do Cadastro Nacional de Estabelecimentos de Saúde (CNES), de modo que não está disponível nos sistemas de informação do Ministério da Saúde a quantidade de equipamentos existentes. O Ministério da Saúde ainda não dispõe de diretrizes nacionais para indicação desse procedimento ou cobertura e não está prevista nenhuma forma de custeio desses procedimentos no âmbito do SUS. Também não há estudos para estimativa da quantidade necessária para atendimento da demanda. A OMS preconiza que, quando necessário, esse procedimento deve seguir os seguintes critérios (WHO-QualityRights, 2012: p.3):

1. Não ser realizada de forma abusiva, sendo indicada com base em diretrizes claras e evidências clínicas;
2. Não ser aplicada em pessoas com menos de dezoito anos;
3. Só ser administrada sob consentimento livre e informado do usuário do serviço;
4. Só ser administrada com anestesia e relaxante muscular;
5. Ser monitorada pelos gestores públicos;

O *National Institute for Health and Care Excellence* (NICE) do Reino Unido, estabelece diretrizes gerais para o uso de ECT, recomendando que esse procedimento só deva ser feito após uma adequada e criteriosa avaliação que aponte: que outros métodos não se revelaram eficazes, a condição clínica, avaliação de riscos e benefícios, considerando inclusive eventos adversos potenciais, particularmente quanto ao comprometimento cognitivo. No Brasil, o Conselho Federal de Medicina (Resolução CFM nº 2.057/2013, Art. 21 a 25) reafirma a obrigatoriedade de procedimentos anestésicos e de recuperação, como condição para administração desse procedimento, além de avaliação prévia do estado clínico geral do paciente, em especial das condições cardiovasculares, respiratórias e neurológicas. Há um consenso da literatura científica quanto à indicação de ECT em algumas situações clínicas específicas, como a depressão refratária a tratamentos farmacológicos, mas apenas 20% a 30% das pessoas com depressão maior não respondem aos tratamentos convencionais (farmacológico e psicoterápico) de forma adequada (Johnston et al, 2019). Diante da baixa prevalência de casos com indicação para esse procedimento e dos requisitos técnicos e de segurança para sua realização, o Ministério da Saúde vem articulando junto aos Hospitais Universitários de Referência a oferta de ECT, somente para os casos em que for efetivamente necessária, obedecendo a critérios rigorosos de indicação. A aquisição de novos equipamentos de ECT justifica-se para a substituição de aparelhos obsoletos e que não garantem condições de segurança adequadas.

17. Por fim, e não menos importante, quais técnicos do Ministério assinaram esta nota? Qual o papel da Associação Brasileira de Psiquiatria na elaboração desta nota?

Resposta: A nota foi assinada pelo então Coordenador, Sr. Quirino Cordeiro Junior. Trata-se de um documento no qual o ex-coordenador trouxe um resumo das principais alterações normativas na Política Nacional de Saúde Mental. Em relação ao papel da Associação Brasileira de Psiquiatria – ABP, informa-se que não existe nenhum vínculo com a Coordenação-Geral de Saúde Mental Álcool e Outras Drogas – CGMAD/MS.

18. Quais foram as referências científicas utilizadas para elaboração da Nota técnica Nº 11/2019-CGMAD/DAPES/SAS/MS? Requeremos, ainda, a íntegra dos documentos, atas, e-mails, estudos e relatórios que embasaram a nota técnica nº 11/2019-CGMAD/DAPES/SAS/MS.

Resposta: A nota traz orientações aos gestores especificamente sobre as alterações normativas citadas em seu cabeçalho. Não se trata de um Protocolo Científico, mas de normas administrativas aos gestores. Como contribuição à bancada do PSOL, encaminhamos referências sobre epidemiologia, custos / peso das doenças mentais e sobre sistemas públicos de saúde mental. (8145271 - An overview of the mental health system in Italy, 8145311 - Global Mental Health 4 , 8145352 - EPA guidance on the quality of mental health services, 8145384 - Professor Graham Thornicroft Institute of Psychiatry, King's College London, 8145407 - Mental health and new models of care, 8145439 - Achieving Better Access to Mental Health Services by 2020, 8145454 - Prevalence of Mental Disorders among Prisoners in the State of Sao Paulo, Brazil).

19. Sem mais para o momento, a Coordenação Geral de Saúde mental Álcool e Outras Drogas - CGMAD, se coloca a disposição para demais informações que se fizerem necessárias.

20. Encaminhe-se GAB/SAS, com vista à ASPAR para providencias.

Documento assinado eletronicamente por **Simone Garcia de Araujo**, **Bolsista**, em 27/02/2019, às 15:11, conforme horário oficial de Brasília, com fundamento no art. 6º, § 1º, do Decreto nº 8.539, de 8 de outubro de 2015; e art. 8º, da Portaria nº 900 de 31 de Março de 2017.

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An overview of the mental health system in Italy

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An overview of the mental health system in Italy

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Summary. This paper intends to evaluate the mental health system in Italy thirty years after the psychiatric reform, using epidemiological evidence on the prevalence of mental disorders and the features of primary care and community mental health services (data from five Regions). The network of community mental health facilities appears to be complete as concerns Residential Facilities and Community Mental Health Centres, and less complete as concerns General Hospital Psychiatric Units. Substantial variation exists between Regions and between disorders, the treatment gap being smaller for schizophrenic than for mood disorders. High quality information is essential to improve mental health care; therefore, it should be systematically collected and extensively used to prime over the next decade a virtuous circle of positive changes.

Key words: mental health system, community care, Italy, psychiatric reform, treated prevalence.

Riassunto *(Il sistema di salute mentale in Italia).* In questo contributo si vuole valutare il sistema di salute mentale in Italia trent'anni dopo la riforma psichiatrica, analizzando evidenze epidemiologiche (da cinque Regioni) sulla prevalenza dei disturbi mentali e sulle caratteristiche dei servizi di medicina di base e di salute mentale. La rete delle strutture psichiatriche riabilitative sembra essere completa per quel che riguarda le Strutture Residenziali e i Centri di Salute Mentale, e meno completa nel caso dei Servizi Psichiatrici di Diagnosi e Cura. Esiste una notevole variabilità tra le Regioni e tra i disturbi mentali: infatti, il *treatment gap* è minore nei disturbi di tipo schizofrenico che nei disturbi dell'umore. Le informazioni di alta qualità sono essenziali per migliorare il sistema di salute mentale; dovrebbero quindi essere raccolte sistematicamente ed essere intensivamente usate per innescare nella prossima decade un circolo virtuoso di cambiamenti positivi.

Parole chiave: sistema di salute mentale, servizi di salute mentale, Italia, riforma psichiatrica, prevalenza trattata.

INTRODUCTION

Thirty years ago the Italian psychiatric reform law (Legge 180) made radical changes to the whole concept of Italian mental health care, which, until then, had combined some components of community care with a prevalent mental hospital care. The new law, the above mentioned Legge 180, stated that community care must stand alone, and this led to the closing of mental hospitals. Thus Italy became the first developed country to base its mental health care solely on a community network of mental health facilities.

This process was neither linear nor uniform, and the effective closing down of the mental hospitals only took place twenty years later, at the end of the 1990s. This closing down process led to difficulties, from the point of view of both providing effective care to people with severe mental illness and of evaluating such care. This switch from institutional to community care should have opened wide horizons for research into mental health services. Research evaluation should have moved from enclosed hospital premises to community, and this, in practice, would have given us the possibility to study the resultant radical changes to mental health policy and to make an in-depth evaluation of the effects of such change. However there was only a limited monitoring of the dramatic change, and thus a partial evaluation of its aftermath, the big chance for such a mental health services evaluation was lost. In any case, for the first time in Italy, mental health professionals and academics were prompted by the psychiatric reform to make an evaluation of mental health care from an epidemiological point of view, and this led to the creation of local centres of excellence in psychiatric epidemiology and mental health care evaluation, as occurred in Verona [1, 2].

Apart from the experience gained in the centres of excellence that were set up, the evaluation of mental health care has been particularly advantaged over the last decade by three national surveys that carried out an in-depth evaluation of the network of community mental health facilities and by the growth of

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mental health information systems at the regional level. Today, it is possible to initiate a more systematic evaluation of the mental health system as the body of evidence in this area has increased enormously since the 1980s [3].

The goal of this paper is to evaluate the mental health system in Italy, thirty years after the psychiatric reform. Under the World Health Organization (WHO) perspective [4] a mental health system is defined as the structure and all those activities whose primary purpose is to promote, restore or maintain mental health. The mental health system includes organizations and resources focused on improving mental health. The building blocks of the mental health system are governance (including mental health plans and legislation), financing, mental health services, primary care, human resources, links with other sectors and an information system. In this paper only the service delivery has been analyzed, *i.e.* mental health services and primary care, which forms the core of the mental health system. Any assessment of the other components exceeds the goals of this paper, although a complete analysis should take them into consideration.

The Goldberg and Huxley model [5] has been used to describe the Italian mental health system, and separate analyses have been made of the epidemiological evidence concerning the prevalence of mental disorders in the general population, in both primary care and community mental health services.

MATERIALS AND METHODS

This paper summarizes the results of major national epidemiological surveys, and analyzes the data from the mental health information systems of five Italian Regions (Emilia Romagna, Friuli Venezia Giulia, Lazio, Liguria and Lombardia).

Data from the regional information systems were collected in order to have comparable figures on patients treated in Departments of Mental Health (DMHs), on the patterns of care and on the activities provided by Community Mental Health Centres (CMHCs). These five Regions were chosen as they have well structured mental health information systems covering the whole Region. Indeed Emilia Romagna, Friuli Venezia Giulia, Lazio and Lombardia the flow of the mental health information is totally computerized, however only half the DMHs in Liguria computerize their data.

For the present study we calculated for the population the crude rates per 10 000 > 14 years old; no adjustment was made for the different Regional age compositions. For instance, the treated prevalence was calculated using as the denominator the total population of the five Regions (about 20 million people) and as the numerator the total number of patients treated in these five Regions.

The data give fairly reliable figures concerning the patients cared in DMHs, though there are still some methodological problems in comparing the Regions (*e.g.* the different network coverage of the private and/or residential facilities, there being no full information system coverage of the Residential Facilities in Liguria and Emilia Romagna). For the specific case of Lazio, data on the whole prevalence were not available, while only figures on patients treated in CMHCs were available. However the treated prevalence was estimated on the basis of the other regional mental health information systems, where the CMHC prevalence was about 95% of the overall treated prevalence. As far as concerns new cases, the evaluation of the diagnostic breakdown was hampered by the frequent lack of available diagnostic information (particularly in Friuli Venezia Giulia and Emilia Romagna where about 40% of the diagnoses were missing).

With regard to the activities provided by the CMHCs, there is wide diversity among the Regions in the classification of CMHC interventions. Therefore it was necessary to group the interventions according to a classification already used in analyzing community care [6]. Community contacts have been grouped in eight activities (psychiatrists' clinical activity, psychotherapeutic activity, nurses' activity, activity addressed to families, coordination activity, rehabilitation activity, social support activity, other activities). The present analysis should be considered an exploratory one as, in some cases, the goal of grouping the interventions was not completely achieved. One example is the activity addressed to families; in two of the Regions such interventions were certainly provided, but could not be identified among the data or were not monitored by the information system.

RESULTS

Mental disorders in the community

Using a summarized measure of population health, called the disability-adjusted life year or DALY (a time-based measure combining into a single indicator the years of life lost due to premature death and the years of life lived with a disability), the Global Burden of Disease Project [7] estimated that the burden of mental disorders in Italy is relevant: 2978 DALYs per 100 000 can be attributed to neuropsychiatric disorders, about 25% of the overall burden of disease in the country. If only mental disorders are considered, they amount to 11% of the burden, on adding also dementia and substance abuse this increases to 21%. Depression alone amounts to 7% of the global burden, while bipolar disorder, schizophrenia, obsessive-compulsive disorder, panic disorder are each 1%. Substance abuse accounts for 5% (alcohol use disorders 3% and drug use disorders 2%), while dementia is 4%.

In the last ten years the main results concerning mental disorder prevalence in communities come from two large surveys: the ESEMeD survey (ESEMeD: European Study of Epidemiology of Mental Disorders) and the Sesto Fiorentino study.

The ESEMeD survey [8, 9] was carried out in Italy in 2001-2003, and interviewed a sample of 4712 Italian citizens. The annual prevalence for common mental disorders was 7.3%, anxiety disorder was 5.1%, mood disorder 3.5% and alcohol disorder 0.1%. The most common mental disorders were major depression (3%) and specific phobia (2.7%). Women were twice as likely as men to report a mood disorder and four times as likely as men to report an anxiety disorder, while men were twice as likely as women to report an alcohol disorder. There was a high co-morbidity of mood and anxiety disorders.

Among the people with common mental disorders the use of health services is relatively scarce. Only one sixth (16.9%) used health services (20.7% of those with mood disorder and 17.3% with anxiety disorder). Among the health services users 38% were cared for only by a general practitioner, 27% only by a psychiatrist or psychologist, and about 28% by both professionals. In terms of severity, 12% of the Italian cases were serious, 35% moderate and 52% mild [10].

Wang *et al.* [11] have given a more in-depth analysis of the use of mental health services. With regard to the relationship between severity of disorder and use of health services in the Italian sample: half (51%) the people with severe mental disorder used health services, only a quarter (25.9%) of those with moderate disorders, and a fifth (17.3%) of those with mild disorders. Only one third (33%) of the people treated by the health services received minimally adequate treatment, defined as at least one month of pharmacotherapy plus at least four visits to any type of medical doctor or at least eight psychotherapy contacts. These results are quite comparable to those of other high income countries.

Faravelli *et al.* [12], assessing 2,363 residents in Sesto Fiorentino, reported that the one-year prevalence of any disorder was 8.6% (excluding depression and anxiety NOS "not otherwise specified"), and higher prevalence was found in women (12.1%) than in men (5.4%). In the last 12 months 4.6% of the sample had suffered mood disorders (excluding depression NOS), while for anxiety disorders the figure was 6% (excluding anxiety NOS). The two disorders with the highest prevalence were generalised anxiety disorders (3.5%) and major depressive episode (3.4%). Social impairment was present in 38.5% of people with mental disorders. The use of health facilities was higher than that reported by ESEMeD: among the population with mental disorders who sought help 87% sought help from their GPs and almost one third were in contact with mental health services, while 7% had no contact with health services.

Mental disorders treated in primary care

The most significant surveys of mental disorder prevalence in primary care settings were carried out in the 1990s. Compared with previous studies, these were far more methodologically advanced: a 12-item General Health Questionnaire was used as a screening tool, identifying cases with scores higher than the GHQ-12 threshold who were then subjected to a structured or semi-structured psychiatric interview.

In 1992 the Verona study [13] involved 1625 subjects. The overall prevalence of mental disorders among those attending primary care clinics was 12.4%, of these 6.7% suffered a depressive disorder (4.7% episodes of major depression and 2% dystymia) and 7.7% some anxiety disorder (general anxiety disorder 3.7%; panic disorder 1.5% agoraphobia, 0.6% other anxiety disorders 1.9%).

The Bologna study [14] replicated the Verona study, and involved 1647 subjects. The overall prevalence was the same (12.4%), but the prevalence of major depression was lower (3.3%) and that of general anxiety disorder higher (6.1%). The severity of impairment increased from sub-threshold cases to fully-fledged cases, and, among the latter, the severity of impairment depended on the extent of the depressive and/or anxiety symptoms. Compared with other mental disorders, major depression was evident because of its greater impairment and disability effects.

A third study focussed on depression [15], and involved 1896 subjects drawn from the different Regions. The prevalence of depressive disorder was 8.4%, with no differences according to geographical area. The severity of the cases was mild in 58% of cases, moderate in 36% and severe in 6%.

Mental disorders treated in mental health services

The Departments of Mental Health

In the Italian National Health Service, the Department of Mental Health (DMH) is the health organization responsible for specialist mental health care in the community, as stated by the Progetto Obiettivo "Tutela Salute Mentale 1998-2000" [16]. Within the Department there are various facilities: CMHCs, Day Care Facilities (DCF), General Hospital Psychiatric Units (GHPUs) and Residential Facilities (RFs). The DMH is in charge of the planning and management of all medical and social resources related to prevention, treatment, and rehabilitation in mental health within a defined catchment's area.

The PROG-CSM survey [17] showed that in 2005 Departments of Mental Health were widespread in all Italian Regions, though the DMH level of complexity varied. More than half of the DMHs included not only Mental Health Services for adults, but also services for substance abuse, child and adolescent psychiatry, and clinical psychology services. Concerning the availability of the whole network of mental health facilities, about eight DMHs out of ten included RFs or DCFs and almost all had GHPUs, while day hospitals were less frequent (they were present in about half the DMHs). The level of complexity in terms of mental health facility availability is high in six DMHs of the ten, intermediate in a quarter and low in one of the ten.

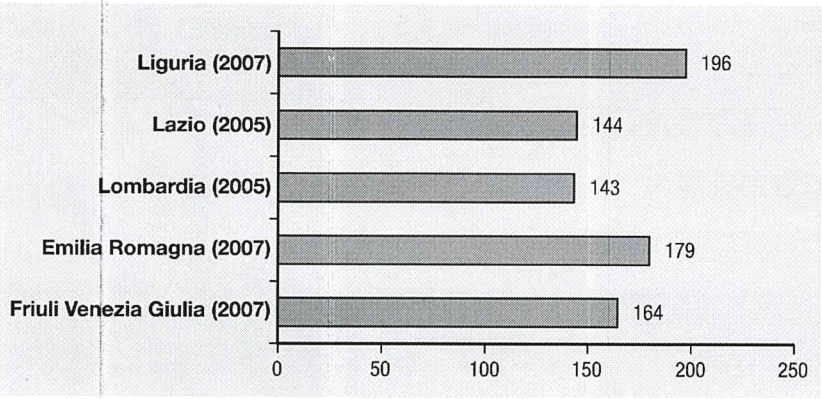

Fig. 1 | *Treated one year prevalence, per Region, in Departments of Mental Health.*

The one year treated prevalence

Treated prevalence provides a measure of the capacity of the mental health system, *i.e.* the total number of people served within the mental health system. Treated prevalence can also be used to estimate the extent of mental health coverage, or, in other words, what proportion of the population with mental disorder is actually receiving treatment.

Data on one year treated prevalence at the DMH level were available from the five Regions *(Figure 1)*. The total prevalence rate, not adjusted, was 158 per 10 000 over 14 years of age. The rate was higher in Liguria, lower in Lazio and Lombardia. Regional variability was not high (average 167, SD ± 24.4).

Table 1 shows the diagnostic breakdown from the one year prevalence data in three Regions (figures from Liguria and Lazio were not available as far as treated prevalence), grouped by the 10th International Classification of Mental Disorders [18]. Note that the reliability and validity of diagnoses in an administrative data set is always open to question, but such figures are a useful tool for a better understanding of the priorities in mental health systems. In our data set, patients with schizophrenic disorders were about one third – one fourth of the patients being treated in public Mental Health Departments. In terms of frequency, the second most common diagnoses were mood disorders – Friuli Venezia Giulia and Lombardia, and neurotic disorders – Emilia Romagna. In all these Regions personality disorders amounted to about one tenth of the subjects. It was quite rare for patients with substance abuse to be treated in a DMH as there are specialized services set up for them. About one twentieth of the patients suffered an organic mental disorder.

With regard to the new cases treated in DMHs *(Figure 2)*, the crude rate was 60 per 10 000 over 14 years old. The rate in Lazio was 3-fold that in Liguria and the Regional variability was higher for new cases (average 58, SD ±23.2) than for cases already under treatment, suggesting marked differences in terms of accessibility between Regions.

As far as concerns diagnoses, neurotic disorders represented the majority of new cases, though there was a considerable gap between Friuli (where they are a quarter) and Emilia Romagna (where they represent about a half) *(Table 2)*. In Lombardia and Friuli Venezia Giulia one patient in four suffered mood disorder, while in Emilia-Romagna this was one in ten. The percentage of patients with schizophrenia was quite homogeneous (around 10% in all four regions). Personality disorders were a bit less than one tenth, with the exception of Friuli Venezia Giulia, where they were less than one twentieth. There is a growing need for care for organic mental disorders, not only in Friuli Venezia Giulia where they represent about a sixth of the new cases, but also in the other Regions.

Using the data of the annual prevalence in public DMHs and that on the utilization of mental

Table 1 | *Treated one year prevalence in DMHs of three Italian regions by ICD 10 diagnostic groups (percentages of cases with diagnoses)*

	Friuli Venezia Giulia (2007)	Emilia Romagna (2007)	Lombardia (2005)
Schizophrenic disorders	30.9%	24.9%	30.7%
Mood disorders	25.5%	17.2%	20.7%
Neurotic disorders	19.2%	33.8%	20.6%
Organic mental disorders	7.3%	3.7%	3.5%
Personality disorders	6.5%	11.8%	11.6%
Disorders due to substance abuse	2.9%	2.1%	2.6%
Others	7.8%	6.4%	7.9%

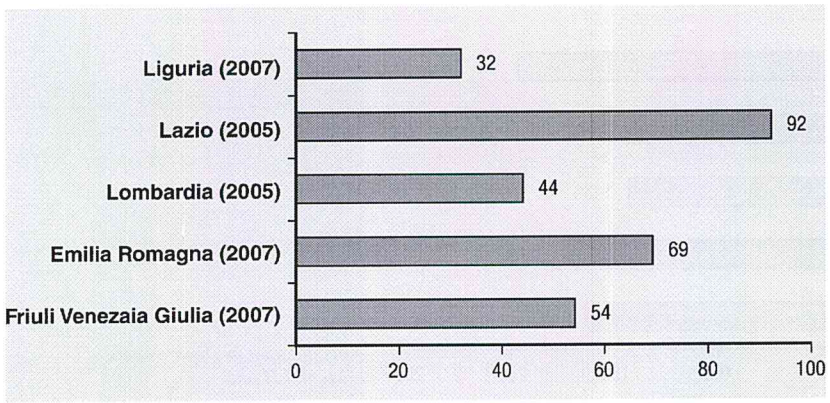

Fig. 2 | *New cases treated, per Region, in Departments of Mental Health (rates per 10 000 >14 yrs).*

health facilities, it is possible to construct patterns of care *(Table 3)*. The present analysis regards four Regions (Friuli Venezia Giulia, Lazio, Liguria and Lombardia) where both sets of data were available. Interpreting the data requires some caveats, because regional information systems differ in their coverage of mental health facilities (*e.g.* in Liguria there were no figures available for residential facilities).

CMHCs treated 93% to 97% of the patients cared for in DMHs. The percentage of acute patients treated in GHPUs varied from 5% in Friuli Venezia Giulia to 22% in Liguria. Only about one patient in twenty was cared for in Day Care or Residential Facilities, though in Friuli Venezia Giulia this figure increases to one in ten.

The treatment gap in schizophrenic and mood disorders

In order to evaluate the capacity of the mental health system to treat mental disorders it is useful to consider treatment coverage and treatment gap. Treatment gap can be defined as the difference between the prevalence of a specific mental disorder in a population and the proportion of affected individuals receiving treatment for the disorder. Alternatively, treatment gap can be expressed as the percentage of individuals requiring care but not receiving treatment [19].

Data concerning the coverage and the treatment gap for schizophrenic disorders cover only DMHs, private psychiatric practice or primary care were not included. In fact it can be assumed that patients with schizophrenic disorders will be cared only for through specialized mental health services. Thus the percentage of patients with schizophrenic disorders treated in such settings is a crucial indicator of the capacity of a mental health system to take care of severe mental illnesses. The Global Burden of Disease study (GBD) [7], estimated that the annual prevalence > 14 years old for highly developed European countries is 0.6%. The treatment prevalence for schizophrenia across Friuli Venezia Giulia, Lombardia and Emilia Romagna was compared to the estimates for schizophrenia from the GBD study. A perfect relationship between estimated rates for schizophrenia and treated cases is a score of 100. On comparing the GBD estimate (0.60%) with the treated prevalence of the DMH in these three Italian Regions (0.33%), the treatment gap is 57%.

The same exercise can be done for mood disorders. For mood disorders, the data analyzed both the DMH data and the estimates on cases treated in primary care. A GBD study and an ESEMeD survey for depressive unipolar disorders resulted in the same figures (3.5%), while the GBD study for bipolar disorders estimated the one year prevalence to be 0.5% for the developed European countries. Therefore the total one year prevalence for mood disorders is 4%. In the three Italian Regions the treated prevalence at the DMH level for mood disorders is 0.30%, while at the primary care level the estimate inferred from

Table 2 | *New cases treated in DMHs of three Italian regions by ICD 10 diagnostic groups (percentages of cases with diagnoses)*

	Friuli Venezia Giulia (2007)	Emilia Romagna (2007)	Lombardia (2005)
Schizophrenic disorders	12.1%	8.8%	9.9%
Mood disorders	25.8%	13.4%	27.0%
Neurotic disorders	28.5%	54.8%	37.5%
Organic mental disorders	13.8%	6.9%	5.0%
Personality disorders	3.7%	9.0%	7.3%
Disorders due to substance abuse	3.7%	3.5%	1.0%
Others	12.4%	3.5%	10.4%

Table 3 | *Patterns of care: patients treated in DMHs by different types of facilities (percentages of patients cared for by each facility type in the overall DMH prevalence)*

	Friuli Venezia Giulia (2007)	Liguria (2007)	Lazio (2005)	Lombardia (2005)
General hospital psychiatric units	5%	22%	9%	12%
Residential facilities	8%	UN	1%	5%
Day care facilities	10%	4%	3%	4%
Community mental health centers	97%	92%	95%	93%

(UN = unknown)

the Italian ESEMeD data is 0.54%. The results are impressive: there is very low coverage of mood disorders in both mental health services (7.6%) and in primary care (13.5%), thus the treatment gap is huge (79%). Data from Sesto Fiorentino are radically different, because in this site there is a extremely high coverage of primary care services and the treatment gap is practically absent.

The network of mental health facilities

Community Mental Health Centres

Community Mental Health Centres (CMHCs) are the core of the community-based system. They cover all activities pertaining to adult psychiatry in outpatient settings, and manage therapeutic and rehabilitation activities delivered by DCFs and RFs.

During 2005-2006, the PROG-CSM survey [17] analyzed, at the national level, the network of CMHCs in 20 regions (except Molise), evaluating about 95% of Italy's CMHCs.

The CMHC/resident ratio was about 1 facility per 80 460 inhabitants. With regard to fulltime staff, each CMHC had, on average, 4 psychiatrists, 2 psychologists, 2 social workers or rehabilitation therapists, and 7.7 nurses. This means about 24.8 fulltime professionals per 100 000 residents. There were few differences between geographical areas: Northern Italy averaged 25.9 professionals per 100 000 residents (SD ± 11.5), Central Italy 28.3 (SD ± 7.4) and Southern Italy 23.7 (SD ± 6.9). However in the same geographical area marked differences exist between Regions: *e.g.* in the North the staff rate in Friuli Venezia Giulia is 3-fold that in Veneto and Lombardia.

The rate of patients treated in CMHCs over a three months period was 90.8 per 10 000 residents. Of this rate, the new cases (first visit to CMHC in 2004) were 38% of the three months period prevalence. On the whole sample, women made up 57%, and considering age, 42.5% were less than 44 years old, 36% were 45-64 and 21.5% were over 64.

With regard to diagnoses, psychotic disorders (mainly schizophrenic disorder) were about 29%, mood disorders 25%, anxiety disorders 22.5% and other disorders 23.5%. For the new cases the diagnostic breakdown was different: psychotic disorders were 14%, mood disorders 20%, anxiety disorders and other disorders each about 26%. A quarter of all the patients received community treatments (home visits, intervention in the community, etc.) outside the CMHC facility.

The CMHC organization, integration and care continuity with other community DMH facilities was very satisfactory in more than 69% of the facilities. At the patient level, more 37% of the CMHCs developed high quality programs to ensure continuity and care coordination for severe mental disorders (including intensive home care, drop-out prevention programs). Integration with other community health and social services was excellent in 31% of the CMHCs, while it was totally inadequate in about 10%. Prevention and promotion programs were not widespread among the CMHCs: only in 18% of the CMHC could these programs be considered adequate.

The CMHC activity is analysed in greater detail, using data provided by the five Regions *(Table 4)*. On the whole the crude treated-patient rate in CMHCs over a one year period was 148 per 10 000, and the variability among the Regions was small (average 158; SD ± 22). Instead, the CMHC intervention rate is 2402 per 10 000 and in this case there was greater variability among the Regions (average 2792; SD ± 1226).

The main activities provided by the CMHC were the psychiatrists' and nurses' activities: they represented 60% of overall CMHC activity in the five Regions. Rehabilitative – socializing, psychotherapeutic and coordination activities were 6-10%, while social support activities and activities addressed to families were less than 5%.

Acute inpatient facilities

Within the DMH system, acute inpatient care is delivered in General Hospital Psychiatric Units (GHPUs). These inpatient facilities with a maximum of 15 beds

Table 4 | *Patients treated and interventions provided yearly by CMHCs, per region (rates per 10 000 > 14 years old)*

	Patients	Interventions
Friuli Venezia Giulia (2007)	159	3.848
Emilia Romagna (2007)	179	4.339
Lombardia (2005)	133	1.731
Lazio (2005)	138	1.709
Liguria (2007)	180	2.334

Table 5 | *Activities provided by CMHCs (percentages)*

Activities	Interventions	Total	Friuli Venezia Giulia (2007)	Emilia Romagna (2007)	Lazio (2005)	Liguria (2007)	Lombardia (2005)
Clinical psychiatrists' activity	Outpatient clinical contact with psychiatrists for forensic psychiatric assessment	29%	26%	20%	37%	46%	30%
Psycho therapeutic activity	Psychological assessment, outpatient clinical contact with psychologist, psychotherapy	8%	5%	2%	19%	10%	9%
Nurses' activities	Outpatient contact with nurse, nurse's home visit, administering psychotropic drugs	31%	46%	35%	25%	26%	28%
Activity addressed to families	Meeting with relatives and carers (without the presence of the patient), psycho-educational Intervention, family groups	4%	5%	4%	NA	NA	7%
Care coordination activity	Staff meeting in the department, meeting with other health and non-health services, meeting with social network	6%	7%	3%	7%	4%	8%
Rehabilitative and socializing activity	Intervention aimed at achieving basic, interpersonal and social skills training, occupational activities or vocational training, sheltered employment activities, leisure and socializing activities, psychomotor and creative therapy, outpatient contact with rehabilitation therapist	9%	4%	17%	5%	9%	4%
Social support activity	Outpatient contact with social worker, social support	4%	3%	2%	6%	2%	7%
Others		3%	4%	1%	0%	2%	5%

(NA= not assessed in the Region)

are closely linked with the CMHCs to ensure continuity of care.

The PROGRES-Acute Project [20] covered the network of acute inpatient facilities in 20 regions (except Sicily) during 2002-2003. Italy had a rate of 0.78 public acute-inpatient beds per 10 000 inhabitants, located in GHPUs (88%), University Psychiatric Clinics (10%) and 24-hour CMHCs (2%). The availability of public acute beds in Italy was approximately 20% less than the official national standard (1 bed per 10 000 inhabitants). The corresponding rate of private beds was 0.94 beds per 10 000 inhabitants. On the whole, in Italy, the rate of acute, short-term psychiatric beds (public and private) was 1.72 per 10 000 inhabitants. Not only did this rate (private plus public beds) present considerable variation across the different regions, the ratio being 8:1, but also the number of public beds varied greatly from the South to the North-East and Centre (by nearly a 1:2 ratio).

Concerning staffing: all public and private facilities had 24 hours coverage, with staff on duty at night. The 301 public facilities employed 8058 professionals, 86.5% of whom worked full-time. The number of staff in private facilities was much smaller (2384 professionals, of whom 1918 were working full-time). The figures show a full-time staff quota per bed in private facilities that is much smaller than in any type of public facility: in the public facilities the staff/patient ratio ranged from 1.44 to 5.17, showing that facilities for acute patients rely greatly on human resources; in contrast, ratios for private facilities were markedly smaller (0.45 staff/patient ratio).

The mean length of stay varies between facilities, with a median number of days per admission of 11.4 in GHPUs, 17.8 in University Psychiatric Clinics, 21.1 in 24-hour CMHCs and 37.6 days in Private Facilities. There was a substantial variation in the length of stay across the different areas: the mean length of stay in the northeast region was almost twice that in the central and southern regions. Even the number of public beds differs greatly between the southern regions and the north-east and central regions. Indeed, the different bed availability could account for the much shorter average length of stay observed for the south.

In 2001 the psychiatric admissions and the number of admitted patient-rates per 10 000 inhabitants in public facilities were 19.8 and 13.4 respectively, whereas in private facilities these were 6.9 and 4.4 respectively. The percentage of "revolving-door" patients (*i.e.* the patients who had had three or more admissions to the same facility) was similar in public and private facilities (8.7% *versus* 8.3%).

The percentage of compulsory admissions was 12.9%, and it varies from region to region. As a temporal trend the percentage of compulsory admissions decreased from approximately 50% in 1975

(3 years before the Reform Law), to approximately 20% in 1984. Ten-years later, in 1994, this percentage had dropped to 11.8% of the total of public psychiatric admissions [21].

Within the context of PROGRES-ACUTI, diagnoses in a sample of admissions were analyzed [22]. Patients with schizophrenia represented 37.9% of the total admissions to public inpatient units and 25.9% to private ones. Patients with bipolar affective disorders were 18.4% in public facilities and 19.6% in private; those with unipolar depressive disorders were 16.1% in public and 20% in private facilities. A second assessment in the PROGRES-ACUTI Project was conducted specifically to address psychiatric inpatient characteristics on a given census day [23]. The public and private facilities showed great differences in age and gender distribution: public facilities admitted mostly young men, whereas one-third of the beds in private facilities were occupied by women aged 65 and older.

Community residential facilities

The PROGRES study [24], a wide national survey, monitored the network of community Residential Facilities (RF) in Italy. In the year 2000, Italy had 1370 Community RFs and a rate of 3.5 beds per 10 000 inhabitants over 14 years of age. There was marked variability (up to 10-fold) in the provision of residential places among the different regions: 73% of the RFs had 24-hour staffing and more than half were (and still are) managed directly by DMHs, and more than three quarters are funded by National Health Service. The mean number of full-time staff was 8.2 and the overall ratio of patients to full-time staff was 1.4:1.

The results of the PROGRES survey also suggested that many RFs provide mostly long-term accommodation: three quarters of them have no formal limitation to the length of stay; resident turnover was, and is, low, there being few new admissions and few discharges, and discharge to independent accommodation is uncommon. For many chronic, disabled patients, RFs represent "a home for life", rather than a transitional facility. The environmental characteristics are relatively good: residential units are small (an average of 12.5 beds each), residents generally living in twin-bed rooms, and generally open spaces, like gardens, are available. Although the study found a homelike atmosphere in many RFs, most facilities have restrictive rules on the patients' daily life and behaviour. The RFs had several external activities targeted at integrating patients within the local community, however 45% of the patients were totally inactive, not even assisting with their facility's daily activities. Standardized assessment instruments and written treatment plans were rarely used. Leisure and socializing activities, psychomotor and creative interventions prevailed in the rehabilitative interventions (*i.e.* aimed at basic, interpersonal and social skills training); family addressed activities were not frequent [25].

A sample of the total population, 2962 subjects, was evaluated in greater depth [26]. Most were males (63.2%) who had never married, and more than 70% were over 40 years of age; 85% received a pension, most commonly because of psychiatric disability. A substantial proportion (39.8%) had never worked, and very few were currently employed (2.5%); 45% of the sample was totally inactive, not even assisting with domestic activities in the facility. Two-thirds had a diagnosis of schizophrenia (68.2%), while the second most frequent diagnosis was mental retardation (13.1%) and the third, personality disorder (8.5%). Co-morbid or primary substance abuse was uncommon. Mental illness had been long-lasting and severe: for seven out of ten patients the severe mental problems had begun more than fifteen years earlier, and in the last five years about fifty per cent of the sample had suffered persistent positive psychotic symptoms. Twenty-one per cent had a history of severe interpersonal violence, but violent episodes in the RFs were infrequent. The majority the total sample of RF residents (58.5%) had never been admitted to a mental hospital or a forensic mental hospital; almost 40% had been admitted, at least once, to a mental hospital, and 1.6% had been detained in a forensic mental hospital.

CONCLUSIONS

The treatment of common mental disorders in primary care: an unsolved problem

Two community surveys [8, 12] assessed the prevalence of common mental disorders in Italy to be about 7-8%, with very concordant figures. These prevalence estimates were generally lower than in parallel surveys carried out in other Western European countries. However on the crucial issue of service planning, namely the use of health services by those with mental disorders, we have radically different figures from these two surveys. Of the two, the Sesto Fiorentino estimates were more optimistic, but limited to one site, while if there is confirmation of the more pessimistic ESEMeD findings we must conclude that primary care accessibility for common mental disorders is particularly low. Given that the two estimates are widely divergent, there is an urgent need for definitive and concordant indications on the coverage of mental disorders in primary care.

About one tenth of the patients cared for in primary care suffer from some kind of mental disorder, and the prevalence of depressive episodes in this setting varies between 3.3% and 8.4%. However surveys like the two mentioned above do not provide a better understanding of the primary care role in the mental health system, because they do not include information concerning the adequacy of the treatment provided to these patients. The ESEMeD study [27] highlighted that in six European countries only one fourth of the patients with affective disorders received sufficiently adequate treatment in pri-

mary care. Further improvements for the treatment of depression in primary care, like the development of collaborative care [28], should be based on solid estimates of the existing adequacy of the usual treatments. Without this piece of epidemiological information it is not possible to adequately monitor the needed improving actions.

The burden of mood disorders is certainly large regardless of the primary care data used to choose for the estimates. A strategic goal for the National Health System is to bridge this gap: it cannot be tackled without proactive and sustained action at the primary care level and without developing a solid referral and back-referral system with mental health services. However, until now there has been a scarcity of both epidemiological information and strategic actions for improving the treatment of affective disorders at this level.

The core of the mental health system: the Departments of Mental Health

The DMH is the core of community mental health care in Italy: such departments are widespread throughout the country, though with different levels of complexity. With regard to the types of facilities present, the DMHs seem quite complete with the exception of day hospitals. The complexity of DMHs is high in terms of mental health facilities, while it is lower in terms of type of specialized clinical services (like child psychiatry, alcohol and drug abuse services) included in DMHs, given that four DMHs out of ten were limited to adult psychiatry.

The data from regional information systems in five Regions, covering about 20 000 000 people, have given us reliable annual figures for patients treated in public DMHs. Indeed, about 1.6% of the population was cared for by DMHs and new cases were 0.60%. The variability among the Regions with regard to new cases is higher than for treated prevalence, suggesting marked differences in terms of accessibility. In the 1980s data collected from psychiatric case registers on one treated prevalence ranged between 0.70-0.97%, while for new cases the range was between 0.12-0.23% [29, 30]. In the last thirty years the mental health system has grown greatly in terms of both treatment capacity (+89% for treated cases) and accessibility (+243% for new cases).

About one fourth of the treated cases in DMHs had schizophrenic disorders, and about a fifth mood disorders; among the new cases these diagnoses were less frequent, while neurotic disorders were the majority (from one third to half) and organic mental disorders a tenth. The DMHs are focussed on treating severe mental illnesses, which was also revealed by regional analyses on resource utilization [31].

As far as concerns public DMHs, the coverage for schizophrenic disorders is about 57%. This result is close to the NEMESIS survey in the Netherlands [32], but is questionable because it depends strongly on the prevalence estimates of population schizophrenic disorders. For example, if we use the other estimates [33, 34], the prevalence rates are lower (about 0.3%) and the treatment gap is practically 0%. In any case, even assuming uncertainty in prevalence, this indicator is useful to monitor system accessibility for patients with severe mental illnesses.

The patterns of care were strongly influenced by the mental health information system coverage, and by the structure of the different regional mental health systems in terms of available facilities. This last issue requires more in-depth analyses, as it is relevant for assessing the adequacy of the National Health System with regard to mental health care.

The network of community mental health facilities: mission accomplished?

Thirty years after the reform (Legge 180) the network of community mental health facilities seems complete, especially as far as concerns RFs, CMHCs and, partly, GHPUs, though a relevant variability still remains among the Regions.

Our analysis revealed that more than nine out of ten of the patients treated by Mental Health Departments had contact with the CMHCs. This means that CMHCs are the hub of community care, and are crucial to developing the whole system's treatment capacity. The rate of professionals working in CMHCs was quite homogeneous for the North, Centre and South of Italy, though there are still differences among the Regions. The rate of patients treated at the CMHC level showed a range of between 130-180 per 10 000. Data from specific research on patterns of care [6] suggest that CMHCs are highly accessible, also for patients with severe mental disorders (in Lombardia about two thirds of the patients with schizophrenic disorders were treated solely by CMHCs). This preliminary analysis from five Regions showed marked variations in terms of contact rate and type of CMHC activities. Further research is needed to evaluate whether these differences derive only from different service delivery levels, or whether they were at least partly related to different information system characteristics. Indeed, the amount of care provided by CMHCs is a central issue for the development of community care: greater delivery of CMHC care calls for a larger CMHC capacity to provide intensive community treatment, in order to respond to acute cases without hospitalization and to implement innovative interventions (*e.g.* early interventions in psychosis or psychoeducational approaches).

Quite different is the situation concerning GHPUs, both in terms of bed availability and, in part, of structural adequacy [35]. The differences are still relevant among Regions and also geographical areas: in 2003, the rate of public beds in GHPUs in the centre and south of Italy was one third below the Progetto Obiettivo standard and that of the North. In the same geographical areas the Private Acute Facilities had double the beds of the GHPUs, but because of the different case mix between public and private facilities, and the often poorly structured coordination with the DMHs, it was practically impossible

for private facilities to replace the care provided by GHPUs. In a country which has one the lowest rates of acute inpatient beds in Europe [36], and where day hospitals are not widespread, there is a high risk that the clinical needs of people with severe mental illness are not met during times of acute crisis if the public GHPU network is weak and the CMHCs are not able to care for these patients in the community.

Let us summarize the results of PROGRES: in Italy, many people with severe mental illness who, previously, would have been treated in mental hospitals are now cared for in residential facilities. However the historical gap in the mental health system of the 80s, *i.e.* the lack of RFs in the community, has been now filled. However there are still some problems to be tackled. First, the provision of residential beds varies greatly across the Regions. Second, analyses of the care process in residential facilities show large heterogeneity, and efforts should be made to improve the effectiveness, and coordination, of care within the Departments of Mental Health. Third, in recent years the number of beds in residential facilities is still rapidly increasing [37, 31], and further RF expansion could hamper, in terms of competition for resources, the provision of intensive and innovative community care by CMHCs. This last is a crucial issue for the development of community care, not only in Italy but also throughout Europe [38].

Information, strategic tool for improving the Italian mental health system

As stated by WHO, good information is needed to obtain a valid and reliable picture of a country's mental health system [39]. Without high quality information it is not possible to reach a planning rationale, the governance of the system is severely hampered, and accountability at both the national and regional levels is impeded. Decision Support 2000+, a US national initiative, has highlighted that the quality of information determines the quality of mental health care [40].

Thirty years after the psychiatric reform there is still no electronically recorded national mental health information system interactive among the Regions, which is a severe gap in the Italian mental health system. The comparisons presented in this paper derive from a few Regions which, over the last ten years, have autonomously developed regional information systems. These figures from the five Regions are preliminary findings and still present some methodological weaknesses, but they give some insight into the enormous monitoring and evaluation potential within the mental health information system.

In 2001 the Regions and the Ministry of Health [41] made a joint statement concerning the implementation of a national mental health information system, but this has not yet been translated into action. Some of the problems met with in this paper, *e.g.* the comparison of CMHC activities because of differences in terminology, would be easily resolved if the Glossary of Community Mental Health Activities, included in the National Mental Health Information System Framework, was applied.

The lack of a national mental health information system severely hampers not only planning and monitoring, but also any analysis of the mental health system. To this day the only data available at the national level is derived from surveys (*e.g.* PROGRES surveys) that have analyzed, in-depth, the individual mental health facility networks; such data provided only a part of the comprehensive picture of the mental health system and were not at all suitable for monitoring changes as mental health information systems can.

How can epidemiological information help the mental health system in Italy? First, we should consider that a unique mental health system in Italy does not exist: after the 1978, Psychiatric Reform regionalizing mental health care, 21 regional mental health systems were developed and these differ greatly in terms of organization, network of facilities, accessibility, care delivered etc. Therefore these differences among the regional systems need urgent evaluation. Second, in the last thirty years much attention has been paid to the development of a network of community mental health services, therefore we should now focus on assessing the overall quality of these mental health systems. This requires to evaluate through mental information system data the usual dimensions of quality assessment, *i.e.* accessibility, adequacy, acceptability, continuity and effectiveness [42]. In Italy, as in the rest of the world [43], there is an urgent need for more research into the mental health system to explore these crucial issues.

However working only at the system level does not meet all the quality needs in the mental health system, also practices at the DMH level need changing. While our knowledge about effective mental health care is growing fast, putting such knowledge into practice and using it in day-to-day patient care often fails [44]. Pincus *et al.* [45] stated that in mental health care "The gap between the care that patients *could* receive and do receive is greater than a fissure, it is a chasm". To fill such a gap, the authors suggest a more efficient dissemination of evidence to clinicians in order to strengthen the measure of quality, the improvement of the informative infrastructure needed for measuring and reporting quality, and the supporting of quality improvement practices at the locus of care. High quality information is also needed for implementing clinical governance at the DMH level [46].

There is growing consensus on the use of evidence-based clinical indicators for improving quality [47]. In Italy the SIEP DIRECT'S Project goes in this direction [48, 49]. This Project, conducted in 19 DMHs, evaluated the quality of care delivered to patients with schizophrenia through a set of indicators (www.eps-journal.com/custom/direct/2008_4-Instrument_2.pdf) based on NICE Guideline recommendations [50]. This tool may increase awareness of the strengths and weaknesses of customary mental care and open the door to improving actions.

From information to action: this is the virtuous circle that we should be implementing over the next decade, promoting high quality information and using it to improve mental health systems and clinical practices.

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Global Mental Health 4

Scale up of services for mental health in low-income and middle-income countries

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Mental disorders constitute a huge global burden of disease, and there is a large treatment gap, particularly in low-income and middle-income countries. One response to this issue has been the call to scale up mental health services. We assess progress in scaling up such services worldwide using a systematic review of literature and a survey of key national stakeholders in mental health. The large number of programmes identified suggested that successful strategies can be adopted to overcome barriers to scaling up, such as the low priority accorded to mental health, scarcity of human and financial resources, and difficulties in changing poorly organised services. However, there was a lack of well documented examples of services that had been taken to scale that could guide how to replicate successful scaling up in other settings. Recommendations are made on the basis of available evidence for how to take forward the process of scaling up services globally.

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Introduction

The past two decades have seen an unprecedented increase in efforts to address global inequalities in physical health care, particularly as part of the UN's Millennium Development Goals (MDGs) initiative. Resources targeting HIV/AIDS, tuberculosis, malaria, and maternal and child health have increased substantially. Development assistance for health grew from US$5·6 billion in 1990 to $21·8 billion in 2007,[1] and there have been similar increases in education and social development activities. Less progress has been seen in the response to mental, neurological, and substance misuse disorders, despite the identification of the large treatment gap[2,3] and a consensus that improved access to mental health care could provide new hope for people with these disorders, especially in the poorest countries of the world.[4,5]

In 2007, *The Lancet* presented a Series of papers on global mental health that reviewed the global state of mental health systems,[5,6] summarised the evidence for effective treatments,[7] identified barriers to service improvement,[8] and examined existing and required resources for mental health care.[9] The series concluded with a call for global action to increase access to mental health services—a process referred to as scaling up.[10] In this report, we assess global progress in scaling up of mental health care in low-income and middle-income countries since 2007.

Definitions of scaling up typically refer to an objective with several common components: an increase in the number of people receiving services (coverage); an increase in the range of services offered; services that are built on a scientific evidence base, usually with a service model that has been shown to be effective in a similar context; services made sustainable through policy formulation, implementation, and financing (strengthening of health systems).

Scaling up has also been used to refer to a process, which includes mobilisation of political will, human resource development, an increase in the availability of essential medicines, and monitoring and evaluation.[11] WHO has described scaling up as "deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis".[12]

Much research on scaling up focuses on resource availability, identification of barriers, and service delivery issues.[11] We have followed this outline in our report. Progress in scaling up of services could most accurately be measured by comparing change in effective coverage—ie, the proportion of people with a mental disorder who receive appropriate treatment.[13] However, such information

Key messages

- There are many examples of mental health initiatives being developed worldwide.
- There is a need to scale up such services in low-income and middle-income countries so that more people can benefit; however, thus far very few innovative services have achieved this goal.
- Barriers to the scaling up of services should be strategically and systematically considered and addressed. Key to this process is to involve all stakeholders, including decision makers to ensure their support and to facilitate sustainability of services, as well as people using mental health services.
- Services should be both evidence-based and locally relevant, ensuring that they take into account all aspects of existing systems.
- Assessment of examples of scaling up is important so that conclusions can be implemented in a practical way. These conclusions should be disseminated in a format that is accessible to implementers of services.

relating to coverage is not widely published in governmental or scientific literatures, particularly from low-income and middle-income countries.[14,15] The absence of available baseline prevalence and service use data in these countries makes accurate measurement of coverage impossible, although recent data suggest that across the range of mental disorders, only a third of people with mental health disorders are treated in high-resource countries, and as few as 2% of people with such conditions are treated in some low-income and middle-income countries.[16,17]

See Online for webappendix

We therefore used a combination of a systematic review of published literature and a survey of key informants (panel 1). We aimed to gather as comprehensive and up-to-date a view as possible of the extent of scaling up of mental health services in countries with low and middle incomes. Additionally, we have been able to identify many programmes from which we drew out themes related to challenges and practical solutions for making progress in scaling up of services.

The literature review and survey identified many examples of services being scaled up (see webappendix pp 10–19), but few met all of our criteria. There were some published descriptions of services that were scaled up to cover increased population numbers (eg, in Brazil,[20] Chile,[21] and China[22]), but most reports described early stages of reorganisation of services[23–25] or preparation of policy and legislation.[26] This outcome could in part be attributable to the length of time needed to plan, implement, and evaluate programmes. Almost half the respondents to the survey reported that progress in

Panel 1: **Systematic review and survey**

Methods

To capture a global perspective, we included English, Spanish, and French language publications in each of the literature searches. We were not able to include literature published exclusively in other languages, including Mandarin Chinese, Portuguese, or Russian, because of resource limitations. With the exception of global organisations (eg, WHO and the World Psychiatric Association), much of what is published is only in English. This factor constitutes a major barrier to sharing and accessing of information for people who are not fluent in English.

Systematic review

A systematic review of the published and grey literature was undertaken (by LM) to identify evidence of scaling up of mental health services in low-income and middle-income countries since 2007. "Scaling up" and "LAMIC" are not widely used terms, and so we used search terms that were deliberately broad, and information for each country was also searched for individually. Countries with low and middle incomes were defined with the World Bank classification (countries with low incomes, lower-middle incomes, and upper-middle incomes were included)[18]—144 countries in total.

Searches covered the period from January, 2007, to November, 2010, inclusive, and used Medline, Embase, Global Health, PsychExtra, PsycInfo, Cochrane Database and DARE, Africa-Wide Information, Index Medicus EMRO, Index Medicus South East Asia, LILACS, IndMed, KoreaMed, and WHOLIS. Search terms used are listed on webappendix p 1. The titles and abstracts of retrieved publications were screened for relevance to scaling up, to treated prevalence, or to the WHO Mental Health Global Action Programme initiative. Further, *International Psychiatry, World Psychiatry,* and *International Journal of Mental Health Systems* were hand-searched, since they were not fully indexed by these databases.

In addition to the scientific databases, we undertook a web search using Google for relevant papers using the terms "scaling up", "psychiatry", and "mental health". References of all relevant studies and publications were scanned to identify any further relevant publications. The Google search, but not references from it, was restricted to PDF articles. The WHO Assessment Instrument for Mental Health Systems[19] was also searched and all reports published from 2007–10 were retrieved (table 1).

Survey

To obtain additional unpublished information, we identified expert key informants with knowledge at the national level of mental health services in low-income and middle-income countries. To a list provided by the WHO Mental Health and Substance Abuse Department (Geneva, Switzerland), we added a wider range of relevant stakeholders including users of services. The very small number of people in many countries qualified to be included in the sample made random selection of people impossible. The web questionnaire (webappendix pp 2–9) included a brief introduction of its purpose, a definition of terms, and 15 questions on progress in scaling up services, resources available, new materials to support scaling up, new alliances for scaling up, and obstacles and lessons learnt.

Participants were emailed and asked to respond to the survey through the www.surveymonkey.com website, or by completing an attached version of the survey. The questionnaire was made available in English, French, and Spanish. Data were analysed (by JE and MS) by grouping free-text data and coding according to categories, with counts undertaken where relevant.

Of the 142 people contacted, 87 (61%) responded, and their characteristics are shown in table 2. Respondents were mainly senior figures at the country level who could reasonably be expected to know about activities beyond their own organisation. 59 countries were represented in the survey, of which 19 (32%) were in the WHO Africa region, 16 (27%) in the Americas region, eight (14%) in the eastern Mediterranean region, six (10%) in the western Pacific, five (8%) in southeast Asia, and five (8%) in Europe. Of these, 20 (34%) countries had low incomes, 20 (34%) lower-middle incomes, 16 (27%) upper-middle incomes, and three (5%) high incomes (figure 1).

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	Total identified	Total relevant
Medline, Embase, Global Health, PsychExtra, PsycInfo	478	9
Cochrane Database and DARE	262	0
Africa-Wide Information	2452	41
Index Medicus EMRO	115	1
Index Medicus South East Asia	1235	0
LILACS	667	0
IndMed	4	0
KoreaMed	14	1
WHOLIS	18	5
International Psychiatry, *World Psychiatry*, and *International Journal of Mental Health Systems*	>28 editions	33
Google (restricted to PDFs)	>170 000 (400 screened)	9
Reference search	NA	8
WHO-AIMS	68	29
Total	..	136

NA=not applicable.

Table 1: **Reports identified, by source**

	Survey respondents (n=87)
Sex	
Male	60 (69%)
Female	27 (31%)
WHO region of country for which survey answered	
Africa	46 (53%)
Americas	25 (29%)
Southeast Asia	16 (18%)
Eastern Mediterranean	9 (10%)
Western Pacific	8 (9%)
Europe	7 (8%)
Classification of country for which survey answered*	
Low-income country	45 (52%)
Lower middle-income country	40 (46%)
Upper middle-income country	23 (26%)
High-income country†	3 (3%)
Type of organisation worked for	
Non-governmental organisation	34 (39%)
Academic institution	33 (38%)
Government department	25 (29%)
Patient organisation	6 (7%)
Multilateral agency	4 (5%)
Other	1 (1%)
Role	
Academic (professor, lecturer, or researcher)	26 (30%)
Director or manager of mental health services or programmes	24 (28%)
Psychiatrist	21 (24%)
Programme advisor, consultant, or coordinator	15 (17%)
Other mental health clinician or specialist (not psychiatrist)	6 (7%)
Other	4 (5%)
Language in which survey completed	
English	69 (79%)
Spanish	13 (15%)
French	5 (6%)

Data are number (% of total). Numbers do not always add up to the total number of respondents (n=87), either because respondents were able to select more than one response, respondents answered questions for more than one country, or responses were missing. *According to the World Bank. †A small number of respondents currently reside in high-income countries although they responded to the survey on the basis of experience in low-income and middle-income countries.

Table 2: **Characteristics of survey respondents**

their country towards scaling up of services since 2007 had been "good" or "very good" (figure 2A).

Political will and the prioritisation of mental health

At the core of global[27,28] and national[29–31] efforts to scale up services is the need for decision makers and political leaders to understand the issues, recognise their importance, and prioritise action to address mental health needs.[32] Our survey identified some improvement in awareness of mental health issues among leaders during the past 3 years, with more than half of respondents reporting "more" or "much more" awareness (figure 2B). Yet about 40% of respondents, from 26 (44%) countries, identified continuing poor awareness and low priority or poor commitment by political leaders as major barriers to development of mental health services.

> "[There is a] lack of political will to provide a workable mental health policy, introduce reforms in health service delivery, and poor funding at all levels of government." (Nigeria)

Survey respondents cited the absence of a national government mental health policy, strategy, or programme as a key barrier to implementation.[23,25,33,34] However, many countries are now updating their mental health policy or legislation (webappendix pp 20–25). Mental health policy is an important component of scale up of services,[35] although it is not in itself sufficient.[26] An analysis of mental health policies in Ghana, South Africa, Uganda, and Zambia, for example, found them to be weak (in draft form or unpublished) and inadequately implemented. They often lacked feasible plans and adequate resource commitments.[36] We also identified examples (see case study of Uganda, panel 2) in which significant progress was achieved without a recent or complete national policy.

> "There appears to be a disconnect in Government regarding expressed interest and support for mental health services and the lack of tangible expressions manifested by resource availability and policy implementation." (Liberia)

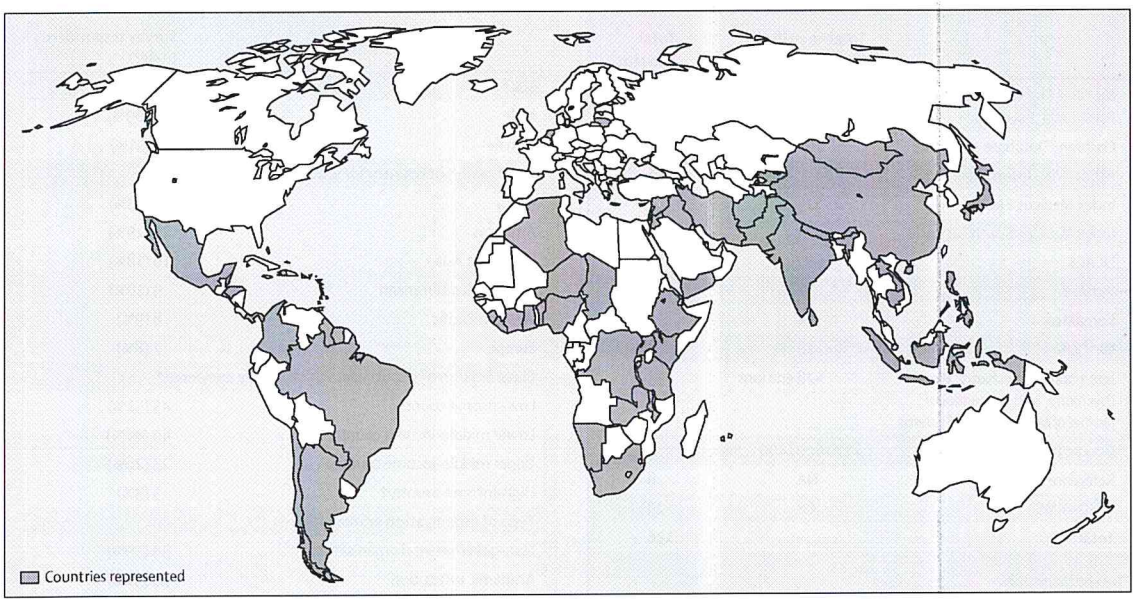

Figure 1: **Countries represented by respondents to the survey**

Legislation provides a clear legal framework that assures respect for human rights as a condition of care, and can also be a lever for change.[39] The UN Convention on the Rights of Persons with Disabilities specifically includes the rights of people with psychosocial disabilities,[40] but there was no evidence that this instrument has yet been effectively used in any country included in the survey.

For the **UN Convention on the Rights of Persons with Disabilities** see http://www.un.org/disabilities/convention/conventionfull.shtml

For more on **Grand Challenges in Mental Health** see http://grandchallengesgmh.nimh.nih.gov

The survey provided a wealth of recommendations to challenge poor government commitment. The main messages were to be persistent, use all relevant evidence of need and of effective interventions, respond pragmatically to opportunities as they arise, use strong stakeholder advocacy groups,[31,41] and clearly allocate responsibility for implementation of plans,[42] including through local management structures.[41]

Poor knowledge and stigmatising beliefs among the general population were also identified as key barriers, reducing willingness to seek help.[29,43,44] Key strategies to change attitudes and helpseeking behaviour were engagement of people using mental health services, their families, and the general community,[41] as well as specific target groups including respected leaders such as village elders[30,39] and traditional health-care providers.[45] Methods included protesting against misinformation and discrimination, sharing of information through direct contact, or use of media.[31] One service model in Nigeria, for example, included a mental health awareness campaign that led to increased use of community mental health services.[46]

At a global level, the central advocacy messages have been to draw attention to the mental health treatment gap,[47–50] reinforce the need to scale up services,[29,51] call for policy and legislation on mental health,[52] and show that evidence-based systems of care should be implemented in the community.[27,53] One initiative strengthening the case for prioritisation of mental health is Grand Challenges in Mental Health. This systematic identification of priorities in mental health is part of the Global Alliance for Chronic Disease. Availability of this kind of evidence has the potential to raise the profile of mental health on the global health and development agenda.[27]

Several new organisations have emerged at national, regional, and global levels whose stated aim is to enable scaling up of services (webappendix pp 26–27). These groups include academic or research bodies, advocacy organisations, and journals. Civil society and non-governmental organisations were repeatedly identified in the survey as playing a key part in strengthening capacity, mobilising funds, and facilitating the implementation of new programmes (figure 2C).

Several global programmes that aim to support efforts to scale up services were identified in the literature review and survey. The Mental Health Gap Action Programme (mhGAP) is the WHO's flagship project in mental health.[54] The objectives of the programme are to reinforce the commitment of stakeholders to increase the allocation of financial and human resources for the care of people with mental, neurological, or substance misuse disorders and to achieve increased coverage of evidence-based interventions, especially in countries with low and lower-middle incomes.[55]

The World Psychiatry Association (WPA) 2008–11 Action Plan is based on a systematic survey of international leaders in psychiatry from almost

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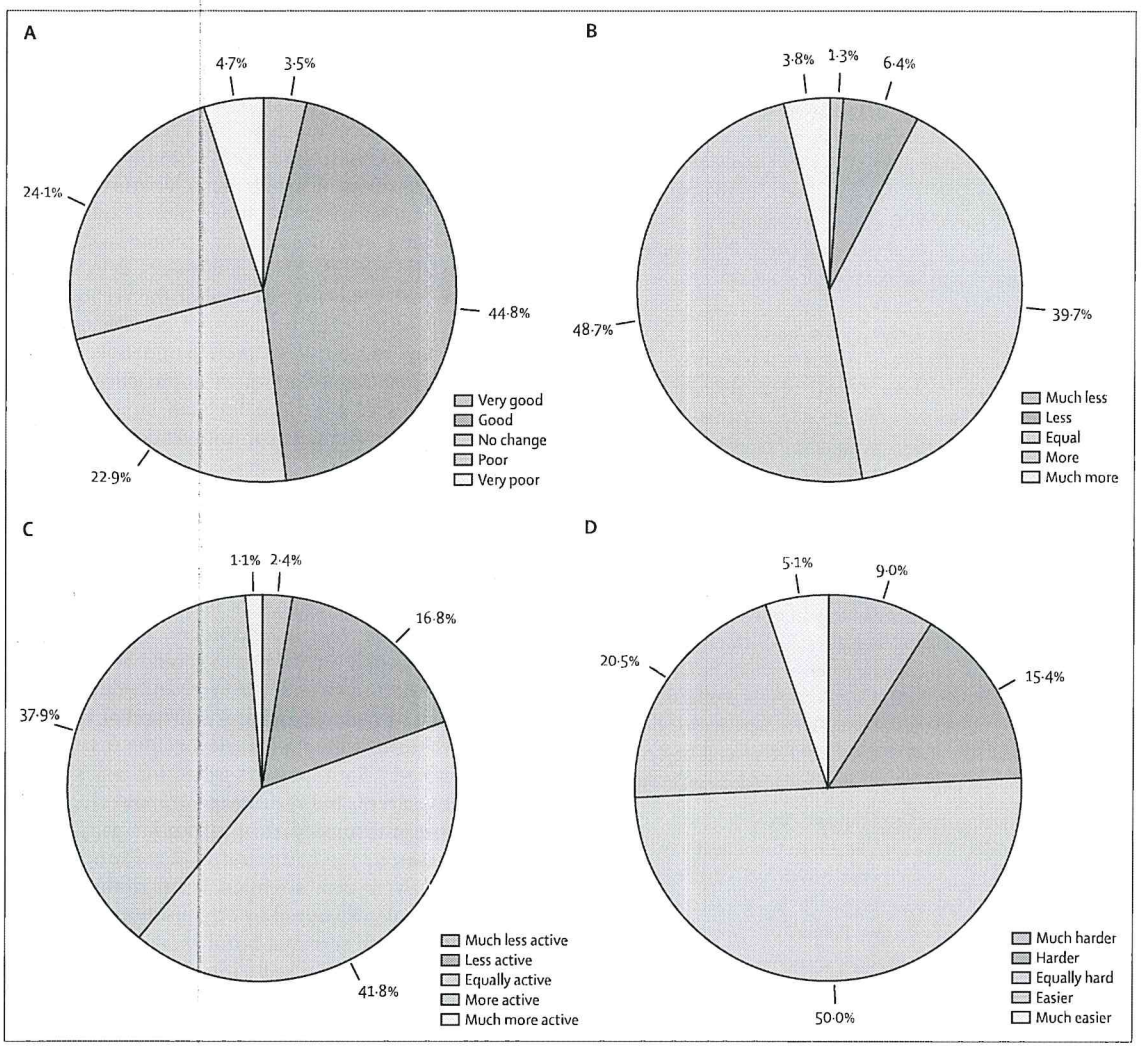

Figure 2: **Survey results**
(A) Respondents' view of country-level progress in scaling up of mental health services since 2007. (B) "In my opinion, the level of awareness among health planners about the need to scale up services compared with 3 years ago is...". (C) "In my opinion, since 2007, in the area of scaling up mental health services, non-governmental organisations/civil sector have become...". (D) "In my opinion, over the past 3 years, mobilising funding for mental health related activities has become...".

60 countries, of which two-thirds have low and middle incomes.[39] The results emphasise strengthening of specialist care while also task sharing (also known as task shifting) in primary care to maximise coverage,[56] increasing access to psychological therapies and social interventions, and the active involvement of people using mental health services and their families. On the basis of these findings, the WPA is implementing a training programme in selected low-income countries.[57]

The Movement for Global Mental Health emerged in 2008 after publication of *The Lancet*'s Series on global mental health.[53] This coalition includes people using mental health services, professionals, and institutions ranging from universities to non-governmental organisations. It aims to be a social movement advocating scale-up of mental health services and protection of human rights.

Organisation of services

Existing structures into which mental health services fit often do not facilitate evidence-based interventions. The continued dominance of large psychiatric hospitals in many countries is at odds with the evidence, which suggests that most services should be delivered in decentralised locations,[24,58] with deinstitutionalisation[39,47] and integration between the community and hospitals,[27,41] and appropriate referral systems incorporating secondary and tertiary care.[33,59,60] There still remains an important role for tertiary hospitals in provision of specialised beds (which remain in short supply compared with need).[30,61]

For the **Movement for Global Mental Health** see www.globalmentalhealth.org

Panel 2: **Integration of services into primary health care in Uganda**

Uganda is an east African country with a population of about 32 million people, of whom more than 80% live in rural areas and 31% live on less than US$1 a day.[37] The Uganda National Mental Health Programme was conceived of in 1999, after collaboration between WHO, non-governmental organisations, and the National Mental Health Programme. The subsequent Health Sector Strategic Plans included mental health for the first time. Key elements included staff training, strengthening of drug supply systems, guideline implementation, and public education. Initial reports described successful implementation,[24] but subsequent evaluations have been more mixed. One qualitative assessment[25] based on focus groups and interviews found that staff in the site studied did not focus on mental health, and psychotropic drugs were not available. Progress is more substantial in districts that have included mental health personnel as members of the District Technical Planning Committee. In 2001, there were few community-based services beyond those supported by non-governmental organisations. By 2010, the Annual Health Sector Performance Report[38] found nine functioning regional mental health units compared with four in 2001, a 75% increase in psychiatric nurses at district level (though some were deployed to other functions), and 80% of all health subdistricts had at least one antipsychotic, one antiepileptic, and one antidepressant drug.

In terms of funding, the first Strategic Plan indicated an allocation of 0·7% of the total health sector budget to mental health—the first time that mental health had a clear budget line. Mental health is now estimated to be allocated about 4% of the health sector budget. Before 2004, most community-based work was done by non-governmental organisations, but this contribution greatly reduced with the end of the Lord's Resistance Army and Karamajong wars.

There is a new Ugandan mental health policy in draft form, and Parliament has approved the drafting of legislation that will replace the Mental Health Act of 1964. These two draft documents are progressive in being rights-based, in promoting community mental health as the priority strategy for service provision, and in recognising the role of people using mental health services and non-governmental organisations in planning, implementing, and evaluating mental health services.

One model for decentralisation is in Ethiopia, where nurses are trained to assume a range of extended roles in district settings, from prescription of drugs to community mental health education.[62] Integration of mental health into primary care has commenced in five regions of Egypt as part of the country's Health Sector Reform Programme.[26] This programme includes staff training with follow-up, supervision, and a referral system to support primary care doctors. In Kenya, the mental health programme that was established in 2001 is now in its second phase involving training, supervision, and medicine supply.[35] Panel 3 shows a case study in the occupied Palestinian territory.

Poor knowledge of mental illnesses among primary health-care staff and scarcity of mental health specialists for liaison and supervision have been identified as key concerns.[25,32,45] Task sharing has proved to be an effective strategy in other areas of health, such as immunisation uptake and management of tuberculosis and HIV.[63] There is growing evidence that lay people and health workers can also provide care traditionally delivered by psychiatrists.[30,43,64–66] However, several of the respondents to the survey stated that unless staff receive ongoing training and supervision, motivation to undertake mental health work is lost. Some innovative approaches in India and Niger addressed the need for staff supervision by using telephones to facilitate communication.[30,67]

The difficulty of giving increased responsibilities to busy primary health-care staff is often cited.[27] A possible solution is the integration of mental health care with services for people with long-term (chronic) conditions,[68–70] since services for individuals with chronic conditions share many of the characteristics of services for people with mental and neurological disorders. There is also a strong consensus that mental health should be integrated with other systems, such as social care[71] and education.[60,72]

Task sharing always necessitates substantial training, but where there is high staff turnover, this investment might be wasted.[34] Some reports called for task sharing with families, carers, and volunteers, empowering them to play a more informed part in caring for people with mental illnesses in the community—a training investment less likely to risk so-called brain drain.[39,41] This peer support is also favoured by organisations of people using mental health services, families, and carers,[40] but this strategy should avoid reducing choice by replacing proper provision of professional services on which people also rely.

Many health information systems (which can include various population-based data sources [eg, censuses or household surveys] or health-facility based sources [eg, public health surveillance, health services data]) do not include mental, neurological, and substance misuse disorders.[73] This factor makes it more challenging for mental health to be regarded as an integral part of the overall health system, as well as jeopardising efficient mobilisation of essential drug supplies, and implying low demand for mental health services.[74]

Even services based on simple packages of care need a sustainable supply of psychotropic drugs,[45,75] and the systems to provide this supply are often weak in low-income settings.[76] In the short term, non-governmental organisations can find innovative ways of ensuring a supply of drugs, but ultimately the solution is to strengthen systems for sustainable provision of essential drugs.[41,76] The availability of psychological therapies is even less than for pharmacological interventions,[34] and is an area with a weak evidence base in low-income and

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Panel 3: **Mental health and psychosocial services support project in the West Bank and Gaza**

The European Union is financing a Mental Health and Psychosocial Services Support Project in the West Bank and Gaza, implemented by the WHO office in Jerusalem in collaboration with the Palestinian Ministry of Health. The goal of the project is to improve the quality, effectiveness, and sustainability of public mental health services through primary health-care services.

In the West Bank, extensive consultations led to a scaling up strategy using a stepped care model of treating common mental disorders in public primary care facilities. The Primary Health Care Directorate and the Mental Health Unit of the Ministry of Health agreed to implement the programme across the 12 health districts of the West Bank. Primary care doctors (GPs) and primary care nurses (PCNs) were trained to identify and treat common mental disorders, with antidepressant use in moderate-to-severe cases, referral to specialist care when indicated, adherence management, and trained PCNs to implement psychosocial interventions. To date, 535 staff in nine of the 12 West Bank districts have completed the necessary training. Ultimately, the programme will be rolled out across all districts, with training and ongoing supervision of the primary care team members.

In Gaza, the mental health care integration plans were preceded by a rapid situation analysis of the prevalence of common mental disorders. 500 randomly selected adults in five primary health-care centres around Gaza were screened with the General Health Questionnaire-12. More than a third (38%) of adult attendees were identified as having mental health problems. An assessment of the skills and attitudes of primary health-care staff showed poor recognition of common mental disorders, inappropriate treatments, and negative attitudes. Introductory courses were held for 200 GPs and PCNs. Additionally, 12 mental health specialists were trained in clinical supervision for primary health-care staff. At present, a pilot programme for integration of care for people with common mental disorders is underway in five primary health-care centres, with plans for further scaling up.

middle-income countries.[55,77] In Chile, scaling up of evidence-based depression care needed an increase in full-time psychologists in primary care centres of 344% from 2003 to 2008.[78]

Evaluation and effect

Although respondents accepted the importance of evaluation in principle, most programmes were not evaluated.[79–81] In a systematic review of community mental health services in Africa, only a fifth of relevant programmes included any evaluation,[59] and our findings accord with this assessment. Of the 56 respondents who described new mental health programmes in their countries, only 22 (39%) reported completed evaluations.

Most research into scaling up of services emphasises two issues: first, there are gaps in metrics and evaluation along with inadequate and incomparable primary data sources and analyses;[82] and second, even well researched pilot projects are rarely scaled up. For example, two randomised controlled trials (in Pakistan and India) evaluated community workers in delivery of care for perinatal depression and dementia, respectively.[64,66] Despite being high-quality studies with positive results, there was not sustained success at integration of such services in health systems after the research trials. This finding emphasises that close collaboration between research groups, government, non-governmental organisations, and other stakeholders is essential from the outset, and that consideration of practical sustainability issues is vital for making services research influential in the real world.

Resources

Financial resource allocation

If services are to be scaled up, a substantial increase in resources and more efficient use of the resources that exist is needed.[9] Absence of funding remains the dominant reported impediment to programme implementation.[23,25,74,83] Tracking of financial resource allocation is one key way to judge political commitment to scaling up of mental health services (panel 4). In some cases, increased allocations of funds have been achieved, as in Chile[21] and Brazil.[20]

Access to evidence-based information: guidelines

The literature review and survey respondents identified several guidelines that have been produced to assist scale up of services (webappendix pp 28–29). Some cover incorporation of mental health interventions into other sectors, such as the Inter-agency Standing Committee guidelines on emergency interventions,[85] and the WHO Community-Based Rehabilitation Guidelines.[86] Others relate to a specific component of mental health work—eg, working with children in war-affected areas.[87]

One series covering treatment of a range of mental illnesses in low-income and middle-income countries was published in *PLoS Medicine* after consultation with more than 100 experts in 46 countries,[12] and describes how non-specialist health workers can deliver effective treatments for mental and neurological disorders in resource-poor settings, and how to integrate this approach into primary care settings with the treatment of other chronic disorders. The targeted disorders included attention-deficit hyperactivity disorder,[88] epilepsy,[89] depression,[90] schizophrenia,[91] alcohol misuse disorders,[92] and dementia.[93]

The mhGAP Intervention Guide for eight priority mental, neurological, and substance misuse disorders in non-specialised health settings[94] was published in October, 2010. These guidelines were the result of a systematic process of evidence collection and evaluation

Panel 4: **Change in financial resources for scaling up of services**

Although systems tracking Development Assistance for Health are becoming more sophisticated,[1] systematic measurement of financing for mental health remains difficult. Mental health is often not identified as a subcategory within non-communicable diseases (NCDs), a diverse category including tobacco control and injuries. Despite recognition of the growing relative effect of NCDs on disability and mortality,[70] less funds were given by government donors in 2008 than in 1995, and WHO spending on NCDs decreased by a third between 2002 and 2008.[84] Where NCD aid funds are intended for mental health activities, this information is rarely disaggregated in reports, although it can be found in the field.[73]

Overall, there is no evidence of a substantial shift in financial investment in mental health care in low-income and middle-income countries, since 50% of survey respondents felt that securing funds for mental health work was no easier than in 2007, with other respondents equally divided between reporting that it was easier or harder (figure 2D). Examples of funding for service implementation identified included national and local governmental agencies (for instance, in Indonesia, Ghana, Kenya, India, and Brazil) as well as UN agencies such as UNICEF and WHO (in particular, the WHO Mental Health Global Action Programme). Other sources included mental health projects funded by donor agencies such as the African Development Bank, African Medical and Research Foundation, Australian Aid Agency, UK Big Lottery Fund, European Commission for Humanitarian Aid and Civil Protection, and the EU Development Fund, as well as funds allocated through international non-governmental organisations such as BasicNeeds, CBM International, Comic Relief UK, and International Medical Corps.

Some new funding sources for research were identified, including from the Wellcome Trust, UK Medical Research Council, global mental health research programmes by the National Institute of Mental Health, as well as international research fellowships by the Fogarty Program at the US National Institutes of Health (NIH). Funding from NIH to mental health increased by 8% between 2007 and 2010, but we could not establish what proportion was devoted to low-income and middle-income countries.

For more on the **Sangath course** see http://www.sangath.com

For more on the **University of Ibadan's course** see http://www.cbmnigeria.com/mh_ibadan.html

For more on the **Indian Law Society's course** see http://www.mentalhealthlaw.in

For more on the **University of Lisbon's course** see http://www.fcm.unl.pt/masterint

using the GRADE methodology.[55] The recommended interventions aim to be feasible and acceptable in low-income and middle-income countries, and should be integrated into existing systems. The mhGAP Intervention Guide is now available in English, French, and Spanish.

Staff training

In most low-income and middle-income countries, the ratio of people who need mental health care to the number of qualified psychiatrists is so disproportionate that there is no prospect of psychiatrists being able to deliver the care that is needed in the foreseeable future.[24,26,43] In India, if every psychiatrist worked full-time, they would succeed in treating less than 10% of people with mental health needs.[32] In countries with low and middle incomes, the psychiatrist should also be a public mental health practitioner,[43] influencing policy makers, overseeing training, and providing support, supervision, and expertise as needed. Shortage of these skills among mental health leaders has been identified as a major barrier to progress in mental health service reform.[8]

This deficit in leadership and public health skills among mental health professionals is addressed by emerging training options (webappendix pp 30–33). One example is the Sangath Leadership in Mental Health Course , and a similar course is run in Nigeria (University of Ibadan), with a focus on Africa. Related courses include the International Diploma in Mental Health Law and Human Rights run by the Indian Law Society, the International Masters in Mental Health Policy and Services run by the University of Lisbon in Portugal, and the Global Mental Health courses at the London School of Hygiene and Tropical Medicine, King's College London, and the University of Melbourne, Australia.

Challenges and lessons learned

Five major barriers to scaling up of mental health services in countries with low and middle incomes have been previously identified:[8] (1) absence of financial resources and government commitment; (2) overcentralisation; (3) challenges of integration of mental health care into primary care settings; (4) scarcity of trained mental health personnel; and (5) shortage of public health expertise among mental health leaders. We examine whether these barriers remain the crucial challenges, and summarise what progress has been made in scaling up.

The central message of the need to scale up evidence-based services in low-income and middle-income countries has been disseminated and has started to be translated into policy, legislation, strategies, and programmes. We found evidence that political leaders and decision makers are giving increased priority to mental health care in some countries, accompanied by an increase in funding by some international development and research agencies, although this change is not yet widespread.

There has been some progress in reorganisation of services by decentralisation and integration into primary health care, in standardisation of models of service delivery (including through an increasing number of well designed trials of complex interventions), and in understanding of the policy environment needed to make scaling up more feasible. There is now experience in several countries in engagement with the whole health system to ensure the necessary resources, such as personnel training and medicine supply, are widely available.

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Figure 3: **Important steps in strategic scaling up of mental health services in low-income and middle-income settings**

There are many examples of training of community and primary health-care staff to take on mental health activities, and even of new grades of staff or reallocation of roles. However, ensuring that trained personnel continue to devote time to mental health activities in the long term remains a challenge, although refresher training and robust supervision structures might improve this situation. Focal personnel dedicated to mental health or chronic diseases (for example, at the district level) might also improve the commitment to delivery of services in a sustainable way.

Although there are examples of services that are being taken to scale, few have been evaluated and shown to be delivering care of a consistent standard to increased numbers of people. Crucially, this finding means that the evidence base for proven strategies for scaling up that are replicable remains weak.

The way forward

A systemic and strategic approach to scaling up is needed (figure 3). Specific interventions to increase coverage of mental health services need to be part of a broader and integrated process. This approach will need strong advocacy for financial commitment and will need to ensure that relevant elements of health infrastructure are strengthened to allow services to be sustained in the long term.

Task sharing is the means to most efficiently use low numbers of trained personnel. A high proportion of need can be met with simple packages of care delivered in non-hospital settings by non-specialists. Primary health-level staff need to be better trained and supported to identify and manage mental disorders. The specific roles they should have, the training and supervision they need, and the way that they relate to the overall health system are important questions to be evaluated.

Specialist mental health staff are needed at the district level. The composition of personnel will vary depending on available resources, and preferably should consist of a multidisciplinary team, but at least a prescribing clinician. In many of the countries represented in our survey, the mere decentralisation of any mental health expertise to district level (rather than only the very largest cities) would have an enormous effect on access to care. Such staff would not only provide clinical services, training, and supervision for non-specialist staff in primary care, but also a managerial function to ensure that the health system facilitates integration of mental health services.

Mental health professionals and practitioners need to broaden their roles. Besides being traditional clinicians, specialist staff also need to accept responsibility for planning, training, supervision, and advocating with decision makers in their area of expertise. To achieve this goal, specialists themselves need access to relevant training in these skills.

Scaled up services need to be evaluated, and the lessons learnt from evaluation then generalised. The evaluation of innovative programmes can make an important contribution to the case for scaling up. Although contextually appropriate services will always differ, effective models will be those that show the best performance for relevant outcomes. To achieve this aim, the evaluation methods used need to be feasible in the context of low financial resources, and routine collection of relevant information is needed.[80] Many countries have used WHO-AIMS, for example, to make initial assessments of their mental health care systems.[10,61] Further refinement and repeated use of this system would add substantially to our ability to measure progress in scaling up. WHO should facilitate coordination of this process, drawing on a network of local experts at country level.

A new paradigm of public mental health is needed. Strong partnerships need to be built between well resourced research institutions and researchers and practitioners in low-income and middle-income countries. This approach should be based on the principles of local capacity building to ensure high scientific standards and participation by all stakeholders, including people using mental health services.

Since 2007, a substantial amount of evidence has shown how feasible and effective services for people with mental illness in low-income and middle-income countries can be. Scaling up of such services can be achieved by tackling, in an integrated way, poor political will, scarcity of resources, and inefficiently organised services, so that care is made available to people who were previously unable to access it. The challenge remains to scale up these services so that an increased number of people benefit, but we have moved a long way in a short time towards this end.

Contributors

JE conceptualised the paper with support from SS and GT. LM undertook the systematic literature review. JE and MS undertook the survey of key informants. FB drafted the panel on financial resources, CN drafted the case study on Uganda, and SC drafted the case study on Palestine. The final report was written by JE with input from all authors and particular editorial support from SS and GT. All authors have seen and approved the final version.

Conflicts of interest

We declare that we have no conflicts of interest.

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Original article

EPA guidance on the quality of mental health services

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ABSTRACT

The main aim of this guidance of the European Psychiatric Association is to provide evidence-based recommendations on the quality of mental health services in Europe. The recommendations were derived from a systematic search of the best available evidence in the scientific literature, supplemented by information from documents retrieved upon reviewing the identified articles. While most recommendations could be based on empirical studies (although of varying quality), some had to be based on expert opinion alone, but were deemed necessary as well. Another limitation was that the wide variety of service models and service traditions for the mentally ill worldwide often made generalisations difficult. In spite of these limitations, we arrived at 30 recommendations covering structure, process and outcome quality both on a generic and a setting-specific level. Operationalisations for each recommendation with measures to be considered as denominators and numerators are given as well to suggest quality indicators for future benchmarking across European countries. Further pan-European research will need to show whether the implementation of this guidance will lead to improved quality of mental healthcare, and may help to develop useful country-specific cutoffs for the suggested quality indicators.

1. Introduction

1.1. Aims

The main aim of this guidance of the European Psychiatric Association (EPA) is to provide recommendations for optimal structures of mental health services by identifying and evaluating the available evidence including a comparison between the efficacy of different service structures wherever possible. One basic assumption of this review is that such services can be viewed as health technologies which are amenable to quality assessment. This view has been discussed by Goldman et al. [61], who concluded that a conceptual framework for assessing the organisation of services as a healthcare technology focuses the attention on scientific evidence to guide program design and policy development.

Epidemiological studies document the large number of people affected by mental disorders in Europe and worldwide [3,4,110,127,146], leading to estimates of treatment needs [82,101,114]. Addressing the need to provide sufficient and competent mental healthcare globally, the World Health Organisation (WHO) has published a range of background policy documents on mental healthcare [136,137,140,141]. Also, WHO published the WHO Pyramid Framework which aims at (i) optimisation of the service mix; (ii) limits on in-patient facilities; and (iii) an extension of out-patient general hospital and community mental healthcare service provision [141].

1.2. Mental health services: models and trends with an emphasis on recent developments in Europe

Mental healthcare structures in Europe have been the objective of several review issues [8,11,12,34,53,116]. Concerning the issue of an optimal mix of services, solutions may differ from country to country due to service traditions, economic constraints, lack of psychiatric experts or other factors. Therefore, the EPA Guidance on the Quality of Mental Health Services includes some general principles with the aim to guide service development and service optimisation irrespective of certain service structures. As many of

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these general recommendations are based on opinions or clinical experience and not on scientific evidence, we have taken care to explicitly state the sources of our recommendations and their evidence grade.

The European Community and the European Observatory on Health Systems and Policies have provided basic data on mental health service structures in Europe [48,82].

One major issue is the process of de-institutionalisation, which means that in-patient facilities are down-scaled in favour of out-patient facilities. Nowadays, community-based services are widespread in the USA and the United Kingdom (UK), but the range of services they provide varies very much across Europe. In the UK, for example, Johnson et al. [75] identified 131 services alone as alternatives to standard acute psychiatric in-patient facilities. Concerning the process of de-institutionalisation in Germany, the so-called "Psychiatrie-Enquête" of 1975 led to a reduction of psychiatric hospital beds and the establishment of a variety of out-patient mental health services like psychiatric out-patient departments in psychiatric hospitals, psychiatric departments in general hospitals and smaller-size psychiatric departments in general hospitals instead of large-size state hospitals [2]. This process has not come to an end yet and in 1997, the German Association of Psychiatry and Psychotherapy (Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, DGPPN) recommended that out-patient and in-patient services should be provided evenly across Germany, and that mental healthcare should follow the preference for the "least restrictive alternative" [41]. As a possible drawback of de-institutionalisation, there appears to be a general trend of re-institutionalisation (defined as a process of readmitting previously discharged long-term patients with severe mental illness into forms of long-term institutional care) of the mentally ill in Europe with increasing numbers of persons with mental illnesses in forensic services and other institutions of legal detention (the latter is often defined as "transinstitutionalisation", e.g., people with severe mental illness are not admitted to a psychiatric hospital, but into a forensic hospital or other forms of legal detention) [13,70,103,106,107,108,109,111].

Variability between countries is considerable but no factors of supreme importance for determining outcome measures were identifiable [11], which means that there will be no simple answers to the central question of this guidance, e.g., what are the decisive structural and process features mediating the efficacy of mental healthcare services. As a means to assess the number and types of mental health services in Europe on a meso- and macrolevel, the European Service Mapping Schedule [74] was developed and implemented [40].

The large diversity of service structures and the scarcity of evaluation studies make it difficult to formulate an evidence-based EPA Guidance on Quality of Mental Health Services and we addressed this by assembling a panel of psychiatric experts from a range of European countries. Standardised performance measures for mental health services are not yet available, but local solutions are frequently reported [144]. However, European-wide standards are needed to assess the efficacy and efficiency of mental health services. This would involve developing quality indicators of specific structures and processes, similar to the 12 quality indicators used in the OECD assessments [66,67]:

- continuity of care:
  - timely ambulatory follow-up after mental health hospitalisation,
  - continuity of visits after hospitalisation for dual psychiatric/substance related condition,
  - racial/ethnic disparities in mental health follow-up rates,
  - continuity of visits after mental health-related hospitalisation,
  - coordination of care,
  - case management for severe psychiatric disorders;
- treatment:
  - visits during acute phase treatment of depression,
  - hospital readmissions for psychiatric patients,
  - length of treatment for substance-related disorders,
  - use of anticholinergic anti-depressant drugs among elderly patients,
  - continuous anti-depressant medication treatment in acute phase,
  - continuous anti-depressant medication treatment in continuation phase;
- patient outcomes:
  - mortality of persons with severe psychiatric disorders.

2. Methods

2.1. Definitions

See Info Box 1 and Fig. 1) for definitions of "Quality" and related concepts, and see Info Box 2 for definitions of "Mental Healthcare"and "Mental Health Services".

Recommendations and quality indicators were structured following a subdivision into macro-, meso- and microlevels of analysis. Macrolevel recommendations or indicators refer to the provision of structural quality on the global or national mental health system level concerning mental health education and mental health monitoring and addressing questions of the general organisation principles of the mental healthcare system in a given country. The mesolevel recommendations deal with aspects of the internal structure of mental health systems within national mental healthcare systems, e.g., structural requirements to ascertain patient needs and dignity, multiprofessionality of services, access to and regional distributions of mental healthcare units, availability of technologies, the workforce, catchment areas organisation and mental health services for ethnic and other minorities. A further subdivision relates to microlevel recommendations, which guide structures and processes within individual service units on a local level (Info Box 1).

2.2. Guidance development process and area of validity

The EPA decided to develop a series of guidance papers on topics related to mental healthcare (see the accompanying introductory paper by W. Gaebel and H.-J. Möller to this issue of *European Psychiatry*). We performed a systematic literature search detailed further below. The EPA Guidance then used the judgment of psychiatric experts – in this case, the co-authors of this paper – to formulate guidance recommendations. This guidance is thus based on recommendations derived from scientific evidence where possible and based on expert consensus. The area of validity for the guidance recommendations and quality indicators is Europe.

2.3. Process of evidence search

In order to identify the most important studies for the evidence base of this EPA Guidance on Quality of Mental health Services, literature and source searches were performed. We predefined keywords with which we searched these databases and we used specified criteria for assessing the relevance of the retrieved documents. All steps of the retrieval and exclusion procedure were documented and are given in detail here. This follows the group on Quality of Reporting of Meta-Analyses of clinical randomized controlled trials (QUOROM group) statement on the improvement of the quality of reports of meta-analyses of randomised controlled trials [105].

Due to the diversity of search terms and due to the many documents retrieved on initial exploratory searches, we performed

Box 1. Quality

To define "quality" is a normative process, which may lead to generic and specific indicators of quality. To implement quality management procedures, it is important to know what is measured and what is necessary to transform the current state to the desired state. Quality will therefore be defined in the areas of structures and processes, which may be optimized. Generic aspects of quality will apply to all mental healthcare, while special aspects will apply only to special settings of mental healthcare. Quality in this context is a dynamic process and has a normative aspect. Essential for future revisions of this guidance will be the question, which processes really occur, in mental healthcare services and how effective these are.

Quality (general definitions, descriptions and examples)

The definition of "quality" in the context of a discussion of general health services or mental health service structures has not yet been universally agreed upon. Several alternatives are available [45]. The American Society for Quality defines quality as *"a subjective term for which each person or sector has their own definition"*. Further definitions are *"fitness for use"* and *"conformance to requirements"* [8]. According to Campbell et al. [25], quality can be defined in a generic or in a disaggregated way. Among the "generic" definitions, the Institute of Medicine (a non-profit, non-governmental U.S. organisation) has defined quality as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"*. The disaggregated approaches focus on the aspect of "quality" as a complex and multidimensional construct, which is defined according to several dimensions or components [25]. Campbell et al. [25] propose that access to and effectiveness of services are the only two domains of quality. Maxwell identified six separate but inter-related dimensions of the quality of healthcare, which offer a framework for establishing standards and which can be applied to any healthcare setting: access to service, relevance to need, effectiveness, equity, social acceptability, efficiency and economy. Concerning the quality of services, Maxwell points out that it is important to examine how the healthcare system performs as a whole rather than its fragmented parts [149]. This is particularly true considering that in our fragmented healthcare systems there is a multitude of services involved in the treatment and care of patients. Harteloh [65] differentiates between a descriptive and a prescriptive approach of the quality concept. While the descriptive approach exemplifies the meaning of quality as a property, the prescriptive approach defines the meaning of quality as a category of judgement. The author explains a rule for interpreting the abstract concept of quality: "the term 'quality' is applied as a ratio of possibilities realised on the one hand and a normative frame of reference on the other". The definition of ISO 8402 [71] is an example for a descriptive definition, where quality is described as an intrinsic property or condition: *"Product and service quality can be defined as the total composite product and service characteristics of marketing, engineering, manufacture, and maintenance through which the product and service in use will meet the expectations of the customers"*. The following definition from Lohr et al. [94] is also an example for a prescriptive definition: *"Quality of care is a multidimensional concept reflecting a judgement that the services rendered to a patient were those most likely to produce the best outcomes that could reasonably be accepted for the individual patient and those services were given with due attention to the patient-physician relationship"*. This is the basic definition, which we followed.

Generic aspects of quality (summary of generally accepted quality standards)

The eight quality management principles of the ISO (International Organisation for Standardisation) are: customer focus, leadership, involvement of people, process approach, system approach to management, continual improvement, factual approach to decision making, mutually beneficial supplier relationships.

The World Health Organisation Assessment Instrument for Mental Health Systems (WHO-AIMS) [139,143] was developed to assess key components of mental health systems for middle- and low-income countries. It still appears to provide a range of useful suggestions for the mental healthcare structures and models in Europe, as some European countries belong to the group of low- and middle-income countries, and since some general recommendations are independent of the income level of a society. This comprehensive instrument consists of six domains: policy and legislative framework, mental health services, mental health in primary care, human resources, public information and links with other sectors, and monitoring and research. These domains address the 10 components of the World Health Report 2001 [136]:

- Provide treatment in primary care;
- Make psychotropic drugs available;
- Give care in the community;
- Educate the public;
- Involve communities, families and consumers;
- Establish national policies, programmes and legislation;
- Develop human resources;
- Link with other sectors;
- Monitor community mental health;
- Support more research.

The WHO-AIMS primarily consists of input indicators, which are related to resources that are used to develop or modify services, and process indicators dealing with the assessment of service utilisation as well as aspects of service quality. As the WHO-AIMS provides essential information for mental health policy and service delivery, countries or regions will have a comprehensive picture of the main weaknesses of their mental health system, and this knowledge can initiate and facilitate improvements. Most items in WHO-AIMS describe aggregate information, but further development of this instrument may involve linking collected data with geographical information systems to map within-country differences [118]. On a regional or national level, the fulfilment of patient needs appears to offer a guide as to translation of findings from psychiatric epidemiology, general health needs and social factors into service facility needs estimates [124]. Discrepancies between staff and patients views may occur, and needs assessment are closely intertwined with questions of patient satisfaction [121]. A draft toolkit to monitor human rights in mental health and social care institutions has been developed by the Institutional Treatment, Human Rights and Care Assessment (ITHACA) project and the WHO Department of Mental Health and Substance Abuse [72,81]. This toolkit can be applied in different settings, like in psychiatric hospitals, psychiatric wards of general hospitals, rehabilitation centres, day centres, community services and high security psychiatry facilities. A schematic overview of the requested human rights is already available. Taken together, a wide range of measures has been developed, but they either focus on selected aspects or seem to be too globally oriented to serve as models for a European guidance.

Quality of structures, processes, and outcomes

Quality of healthcare in general has been classified by Donabedian [45] in the three categories: "structure", "process" and "outcome". This is the basic distinction which we have followed here. "Structure" constitutes the attributes of care settings like facilities, equipment, human resources and organisational structures. "Process" indicates the activities in giving and receiving care which includes the activities of healthcare providers. "Outcome" as the third category

denotes the effects of care. According to Donabedian, information about the relationships between structures, processes and outcomes should be ascertained before quality assessment can begin [45]. Campbell et al. [25] suggest that structure is not a component of care but the conduit through which treatment and care is received and delivered. Thus, outcome is not considered a component but rather a consequence of treatment and care. "Structures" may increase or decrease the likelihood of receiving high quality care because they can have a direct or indirect impact on processes and outcomes, e.g. if special equipment is not available. Corresponding to Donabedian's framework for quality of care, Hermann et al. [66] defined structure, process and outcome as the key domains of quality. Probably the first quantitative study, which applied Donabedian's model to quality systems came to the result that structure correlated strongly with process and outcome [85]. Organisational characteristics associated with better disease control were reported, e.g., from diabetes research [73]. However, there are no current procedures or definitions specifically addressing these issues in mental healthcare. Following Donabedian's model, Kilbourne et al. described a framework for measuring quality and promoting accountability across mental and general healthcare providers [78].

Quality assessment

Two types of organisational quality assessment can be distinguished: (a) mandatory and (b) optional data collection and evaluation programmes. While compulsory assessment is often carried out by governments or agencies, the voluntary quality assessment is usually carried out by professional organisations [87]. Donabedian's framework can be used to evaluate quality based on structure, process and outcome. Quality assurance procedures should result in quality maintenance and ultimately improvement. This may not always be the case as programs or projects may not comply with professional standards [76]. Targeted quality measures can be used for quality improvement within an institution (internal quality improvement) or across institutions (external quality improvement). As evidence in healthcare quality is frequently unavailable, guidelines and quality indicators based on consensus techniques may be needed to facilitate quality improvement. As measuring alone will not automatically lead to improvement, indicators have to be used within systems of quality improvement measures [26]. External quality improvement should be characterised by explicit, valid standards, by structured assessment procedures and complementary mechanisms for implementing improvement [87]. Usually, continuous quality activities aim at improving the structural and process components of care to ascertain positive effects on outcomes [64]. However, it should be noted that quality improvement cannot succeed if it is associated with disproportionately exaggerated documentation efforts or unacceptable for users for other reasons [81]. Thus, both utility and feasibility are essential in developing effective quality improvement measures for clinical practice.

Quality indicators

Indicators are described as explicitly defined and measurable items which act as building blocks in the assessment of healthcare. They may take the form of a statement about the structure, process or outcomes of care. An indicator can also be defined as *"a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality, and hence change in the quality, of care provided"* [91]. Indicators need to be based upon scientific evidence of acceptability, feasibility, reliability, sensitivity to change and – most important – validity. Obeying this rule, the effectiveness of quality indicators in quality improvement strategies can be maximised [26,51]. Quality indicators for mental health service structures and processes especially related to treatment processes for specific disorders are currently being developed and cover a range of processes and structures [67–70,89,91–93,120,123,147,148].

For the present guidance, we had to take into account a complex interrelationship between mental health service structures, outcomes and quality indicators (Fig. 1).

As can be seen from the figure, mental health services are characterized by structural and process elements for which any number *n* of quality indicators may be defined. These generic quality indicators are useful to assess the quality of services or provide benchmarking indicators for comparing individual services in different places. Outcome is assessed by outcome quality indicators. They are different from quality indicators for mental health service structures, but the quality of mental healthcare service structures may be assessed using outcome indicators. Therefore, some outcome indicators may overlap with quality indicators of mental health service structures.

Mental health services in general should provide both structural and process quality. For example, minimum staffing requirements may be necessary for a certain service structure (QI_S), or certain process rules must be adhered to for a certain service under certain circumstances (e.g., rules for the time until a newly admitted patient is seen by a psychiatrist; QI_P). These quality indicators allow quality assessments of the service structure and its processes per se, they are determined by empirical studies and may then become normative features, or they may be defined via patient outcomes. They may also serve for inter-service benchmarking. Outcome assessments are performed, for example using clinical outcomes like disease remission rates (QI_O), and these are values and not service structures or processes. However, patient outcomes are influenced by service structures and processes and therefore service-specific quality indicators may also be defined as outcomes (QI_P or QI_S may then be identical to QI_O). Other outcome quality indicators may comprise patient satisfaction, retention in services, frequency of readmissions, social functioning, activities of daily living and many others.

Quality management

Some techniques and concepts of Total Quality Management incorporated into the management of mental health organisations arose from the manufacturing and industrial sectors mainly to reduce costs [139]. The International Organisation for Standardisation (ISO) and the EFQM model (European Foundation for Quality Management) are examples of industrial models of quality improvement that have been applied to healthcare. The EFQM model promotes quality improvement through self-assessment while ISO focuses on the implementation of international norms [90].

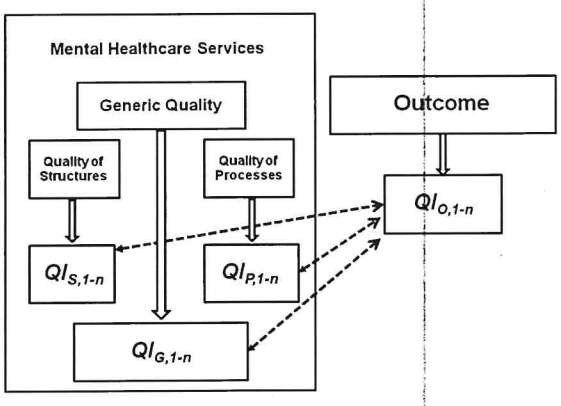

Fig. 1. Complex interrelationship between mental healthcare service structures, processes, outcomes and quality indicators. QI = quality indicator. The suffix "G" denotes a generic indicator, the suffix "S" denotes a structure indicator, the suffix "P" denotes a process indicator, the suffix "O" denotes an outcome indicator. Any number *n* of quality indicators may be defined for a given mental healthcare service.

Box 2. Mental Health Services

For the purpose of this guidance, we define mental health services as the "Specialist provision of mental health and social care provision integrated across organisational boundaries." (Source: A National Service Framework for Mental Health; National Health System; http://www.acutecareprogramme.org.uk/silo/files/national-service-framework-for-mental-health.pdf). A psychiatric service is any service providing diagnosis, treatment and other types of healthcare to people with mental disorders and in which a psychiatrist has the final medical responsibility (this definition was created by the authors of this guidance, since no standard definition for the term "psychiatric service" could be found). European mental healthcare services are characterized by a mixture of in- and out-patient services with curative or rehabilitative approaches. In addition, there are services which integrate in- and out-patient services. We have studied the following service types. This selection was made by the authors of this guidance with the aim to cover all mental health services:

1. Hospitals/In-patient services
2. Out-patient services
2.1. Home-based Treatment (used here as a term for a specialised form of community-based care)
2.2. Community Mental Health Teams (used here as a term for a specialised form of community-based care)
2.3. Intensive Case Management (used here as a term encompassing both assertive community treatment and case management)
2.3.1. Assertive Community Treatment
2.3.2. Case Management
2.4. Day Hospitals
3. Rehabilitation Units
4. Integrated Care Models

We used the term "out-patient services" here as a supraordinate term for several types of out-patient services, which are further specified and described in separate chapters. Note that Rehabilitation Units may be provided in in- and out-patient settings, but are dealt with here separately because of the special nature of rehabilitation services. Also, integrated care models would be expected to cross the border between in- and out-patient services and provide access and treatment in both areas. In some countries like Germany, out-patient mental health services are mainly provided by psychiatrists in private practices. However, there are currently no systematic studies on quality indicators or structural or process recommendations yet available for this special type of mental health services.

Hospitals/In-patient Services

In-patient services provide treatment and stabilisation when the required services cannot be delivered in community settings [127–129]. There are certain groups of patients, who usually require high-intensity immediate support in acute in-patient hospital units (sometimes also on a compulsory basis):

- patients who need urgent medical assessment;
- patients who suffer from severe and co-morbid medical and psychiatric conditions which cannot be controlled on an out-patient basis or in other kinds of settings;
- severe psychiatric relapses and behavioural disturbances;
- strong violence, suicidality;
- acute neuropsychiatric conditions;
- old age and severe concomitant physical disorders.

Mental health services in general hospitals include psychiatric in-patient wards, psychiatric beds in general wards and emergency departments, day hospitals and out-patients clinics. They serve a range of diagnostic and demographic groups and some offer specialist services for specific disorders or patient groups [137–139]. The availability of psychiatric beds in the European countries varies greatly, but there are considerable methodological problems in comparing "psychiatric bed" numbers between countries due to incomplete reporting or varying definitions of service classes between countries [142]. Thus, the large variation of psychiatric hospital beds among European countries may be due to a number of factors including reporting standards and organisational issues.

Out-patient services

Out-patient services can be provided in different settings, such as primary care health centres, general hospitals and community mental health centres, where diagnostic assessment and treatment is offered [126]. Most of them are staffed exclusively with medical doctors (around 80%), 9% include psychologists, 17% provide care by nurses according to service mapping data in England. Some of these clinics function as specialist services, e.g. for people with eating disorders, or in need for various kinds of rehabilitation [60].

Day hospitals

While the function of day hospitals formerly was to mainly provide a place for follow-up-treatment after an acute in-patient episode, they increasingly take a role in the acute treatment of mentally ill [77]. They may even be an alternative to in-patient treatment for many acute care patients. Day hospitals are facilities which offer intermediate interventions between full-time hospitalisations and out-patient care.

Rehabilitation units

Rehabilitation settings for people with mental illnesses generally include rehabilitation units in psychiatric hospitals or specialised psychiatric rehabilitation in-patient units, vocational services and day activity/recreational services [29,113,114]. Evidence-based practice is increasingly implemented and the evidence is strongest for assertive community treatment, supported employment and family psychoeducation [14]. However, implementation of these interventions is often impeded by motivational and organisational barriers even if the required structures would be available [98]. In Europe, generally accepted standards for psychiatric rehabilitation units are currently not available. In Germany, the national working group on rehabilitation ("Bundesarbeitsgemeinschaft für Rehabilitation") has issued recommendations for basic structural and organisational requirements for psychiatric rehabilitation. These include, among others, that rehabilitation units should be available close to the clients' home, that services should be well coordinated between rehabilitation and general practitioners' services, that members of the social environment of those in need of psychiatric rehabilitation should be involved in the rehabilitation process, and that an interdisciplinary team of mental health professionals should be available [17]. There is a clear common understanding that rehabilitation should be offered primarily in the natural environment of the affected persons.

Community-based care

Community-based mental healthcare services comprise out-patient clinics, day hospitals, home treatment services, and community mental health teams in community mental health centres [115]. According to Thornicroft and Tansella [129], a community-based mental health service provides a full range of mental healthcare to a defined population and is dedicated to treating and helping people with mental disorders, in proportion to their suffering or distress, in collaboration with other local agencies. Thornicroft et al. [130] also mention that there are wide inconsistencies between and within countries in how community – oriented care is defined, interpreted and provided. The objective is a "balanced care model", which provides most services in community settings while hospital stays should be reduced as far as possible. Services need to be adapted to the specific needs of low-resource-, medium-resource- and high-resource-countries, low resource areas may

need to focus on the provision of mental healthcare through primary care, while areas with medium resources should provide more differentiated services. High-resource areas should provide all specialised services (e.g. in-patient care, community care, residential and rehabilitation care, alternative occupation) [126,128,129]. Types of diagnoses treated in community-based services largely depend on local, regional and national availability of the respective services, traditions and the availability of alternative types of services. Community-based treatment services usually are provided by an interdisciplinary team of mental health professionals. Treatment focuses on improving quality of life and on reducing the need for in-patient care.

Home treatment

Home treatment or crisis resolution teams offer mobile services and play an important role for acute and emergency treatment. Their services try to avoid in-patient care from the outset [9,20,21,60,132].

Community mental health teams

Community mental health teams (CMHTs) comprise nurses, one or more psychiatrists, social workers, psychologists, occupational therapists and possibly other professionals such as counsellors. They provide short- and long-term care. Usually, patients meet the mental health professionals at the team base [60].

Intensive Case Management

This term now incorporates both assertive community treatment and case management [43,115].

Assertive community treatment

Assertive Treatment teams (ACT) are also called "Assertive Outreach Teams" (e.g., in the UK) and are widespread by now. Assertive community treatment teams comprise psychiatrists, nurses, social workers and occupational therapists and are intended to provide long-term care for rather "difficult" patients, e.g., patients who do not accept treatment. The functions of ACTs are medication management, monitoring the state of health and to offer help in everyday life [9,60]. Assertive community treatment can be viewed as a specialised form of case management, not a categorically different approach [18]. It is usually defined by treatment manuals and fidelity scales, and it includes special features such as daily team meetings, case sharing, 24 hour availability and doctors as full team members [99].

Case management

Case management includes the coordination of various services and aims for continuity of care and service. Case management combines the activities of linking (referring patients to all required services), monitoring and case-specific advocacy. A case manager serves a certain number of patients and has to cooperate with several mental health services [43,115].

Integrated care models

Kodner and Spreeuwenberg [83] provided a comprehensive definition of integrated care based on a terminological clarification of the different meanings of the term "integration": "Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called "integrated care". Integrated care models thus constitute an organisational framework in which important therapeutic modules are administered according to individual requirements especially for people with severe mental illnesses like schizophrenia. These models facilitate synergies between out-patient and in-patient care and also should ascertain continuity of care [134]. In Germany, some of these models have been tested but only few – mainly health economic – evaluations are available [10]. As a special type of integrated care, the so-called regional budget in Germany involves the authorisation of a single provider of mental health services to finance a model of multi-sector mental healthcare services. This has been shown to have complex effects on total costs, modes of service provision, and some beneficial effects on patient outcome parameters [84,112].

Integrated care is used here in a narrow sense describing specialised mental health services following a set of standardized interventions and services. For example, the integrated care pathways (ICPs) for mental health standards have four main elements:

- process standards describe the key tasks which affect how well ICPs are developed in an area;
- generic care standards describe the interactions and interventions that should be generally offered;
- condition-specific care standards describe the interactions and interventions that must be offered to people with a specific condition;
- service improvement standards measure how ICPs are implemented and how variations from planned care are recorded [108,109].

the database literature searches sequentially and updated them if appropriate because of the time lag between the first search and the preparation of the final version of the manuscript. The first of our literature searches was on the quality of mental hospitals and details of the methods are given in Fig. 2.

Fifteen documents retrieved by this search are mentioned in the text [1,16,24,33,42,46,47,55,62–64,68,79,86,128]. This search strategy was supplemented in a second search on controlled trials and systematic reviews on a variety of mental health service structures. The exact search terms and methods are shown in Fig. 3.

This resulted in the additional identification of three controlled studies [7,32,88] and four review articles [28,50,80,131], which were used in this text.

We performed a further literature search in Medline (from 2005 on) on August 9, 2011, in order to better cover out-patient services and the details are given in Fig. 4.

One study showing reduced hospitalisation rates after out-patient waiting time reduction was used for the guidance [145], and another article dealing with in-patient mental health, which had already been identified previously [146]. We also screened the following papers of international and German journals, which published articles on the quality of mental healthcare in 2010, because this was the year in which most of the information retrieval work for this guidance was performed:

- *International Journal for Quality in Health Care*;
- *Journal for Health Care Quality*;
- *Quality Management in Health Care*;
- *Quality Assurance in Health Care*;
- *Gesundheitsökonomie und Qualitätsmanagement*;
- *Deutsches Ärzteblatt*;
- *Psychiatrische Praxis*;
- *Nervenarzt*;
- *Die Psychiatrie*.

Websites of various international and national institutes and organisations have also been screened once in early 2010 by K.S.:

- Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen;
- Institut für angewandte Qualitätsförderung u. Forschung im Gesundheitswesen;

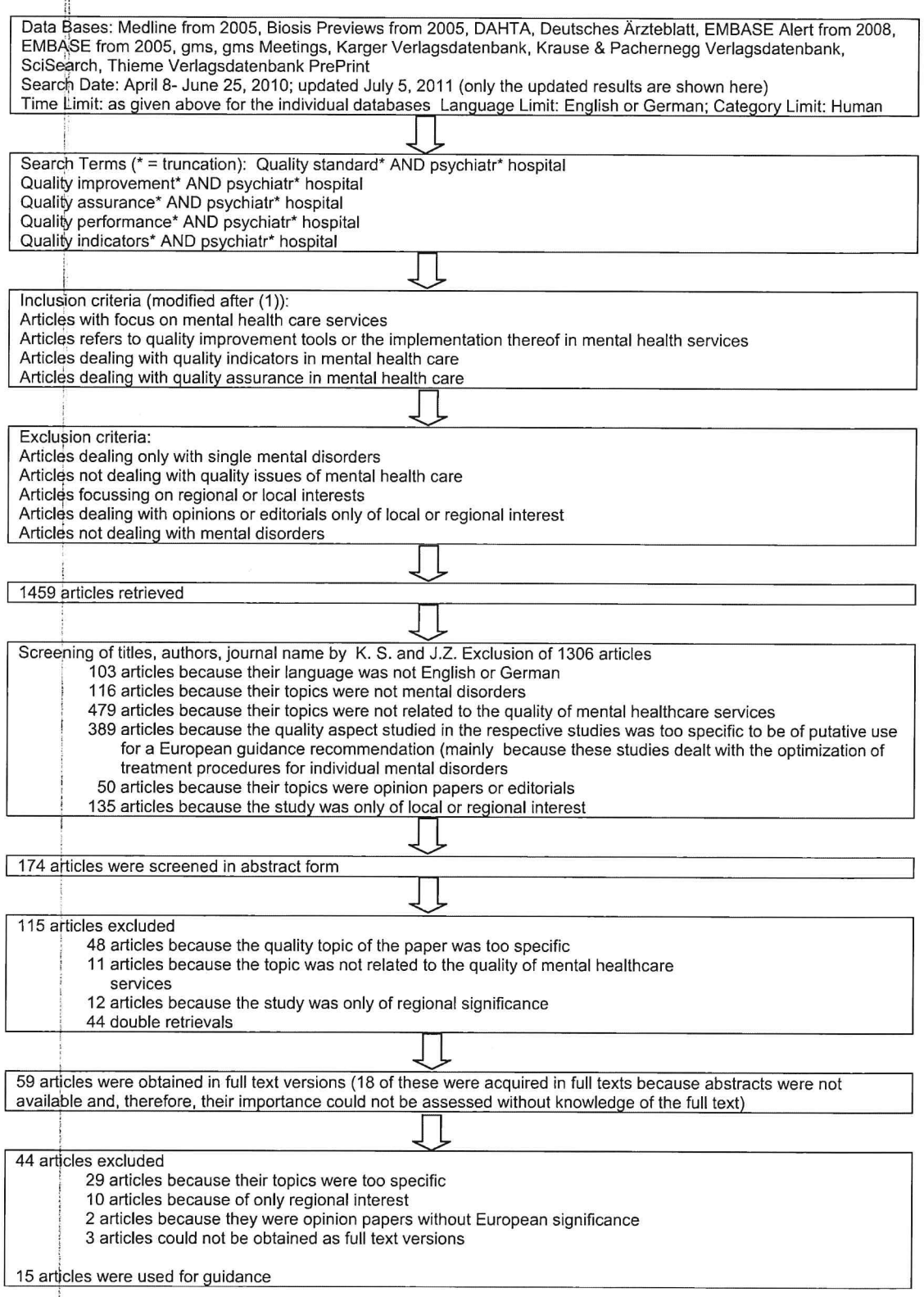

Fig. 2. Flow scheme of the initial literature search and the results pertaining to quality assessments in mental healthcare (see Figs. 3–4 for further literature searches).

- Dt. Krankenhausgesellschaft;
- Agency for Health Care Research and Quality;
- Maryland Hospital Association's Quality Indicator Project;
- WHO;
- Swedish Council on Health Technology Assessment;
- National Institute of Clinical Excellence (NICE-UK).

Further articles were identified by obtaining "related documents", which is a feature of the Medline database providing a list of publications which deal with similar publications compared to

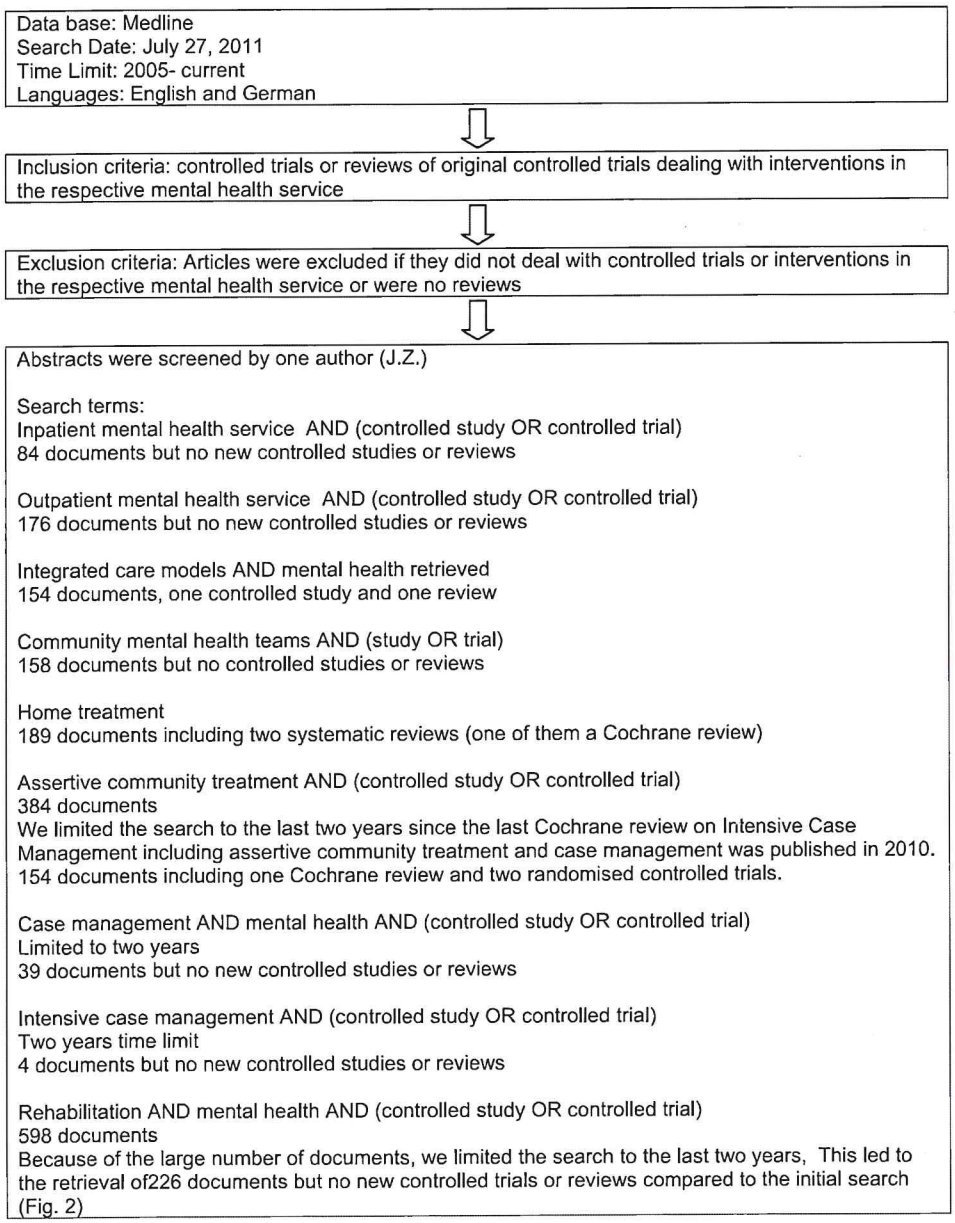

Fig. 3. Flow scheme of literature search specified for controlled single studies and review articles on specific types of mental healthcare.

those identified in a Medline search. These were screened by one co-author (J.Z.) whereby due to the large number of "related documents" only the first 100 were considered if the number of related documents for a retrieved document was larger than 100. Also, articles were identified because they were known personally to the authors or because the authors became aware of them when reading the documents which we had obtained. The total number of articles obtained via colleagues, related documents information, Website visits, reading articles and the reviews of the beformentioned journal homepages was $n = 128$, but we did not keep track of the dates or retrieval steps of these articles.

2.4. Process of developing recommendations

The recommendations were subjected to peer review by the co-authors, the Steering Committee of the European Psychiatric Association European Guidance and the Executive Committee of the EPA. We structured the guidance recommendations into structure and process as well as general and specific recommendations (Table 1). Whereas general (or "generic") recommendation and quality indicators (QIs) apply to all types of mental health services, service-specific QIs are only applicable to a certain type of mental health services, but not to other types. Outcome was not used here as a separate quality category since many studies assessed the results of their investigations on structure or process quality with the help of outcome measures. However, the range of applied psychiatric outcome measures is vast and encompasses patient-based outcomes (like the subjective quality of life in single patients, individual or group-wise clinical assessments of global or disease-specific psychiatric symptom scales and function scales including assessments of employment, independent living or death rates), administrative outcomes (like contact rates in various settings, hospital readmission rates, therapy rates like medication prescription rates, costs) or combinations thereof [59]. It needs to be defined what would be clinically meaningful outcome measures applicable to all European countries, all mental health service

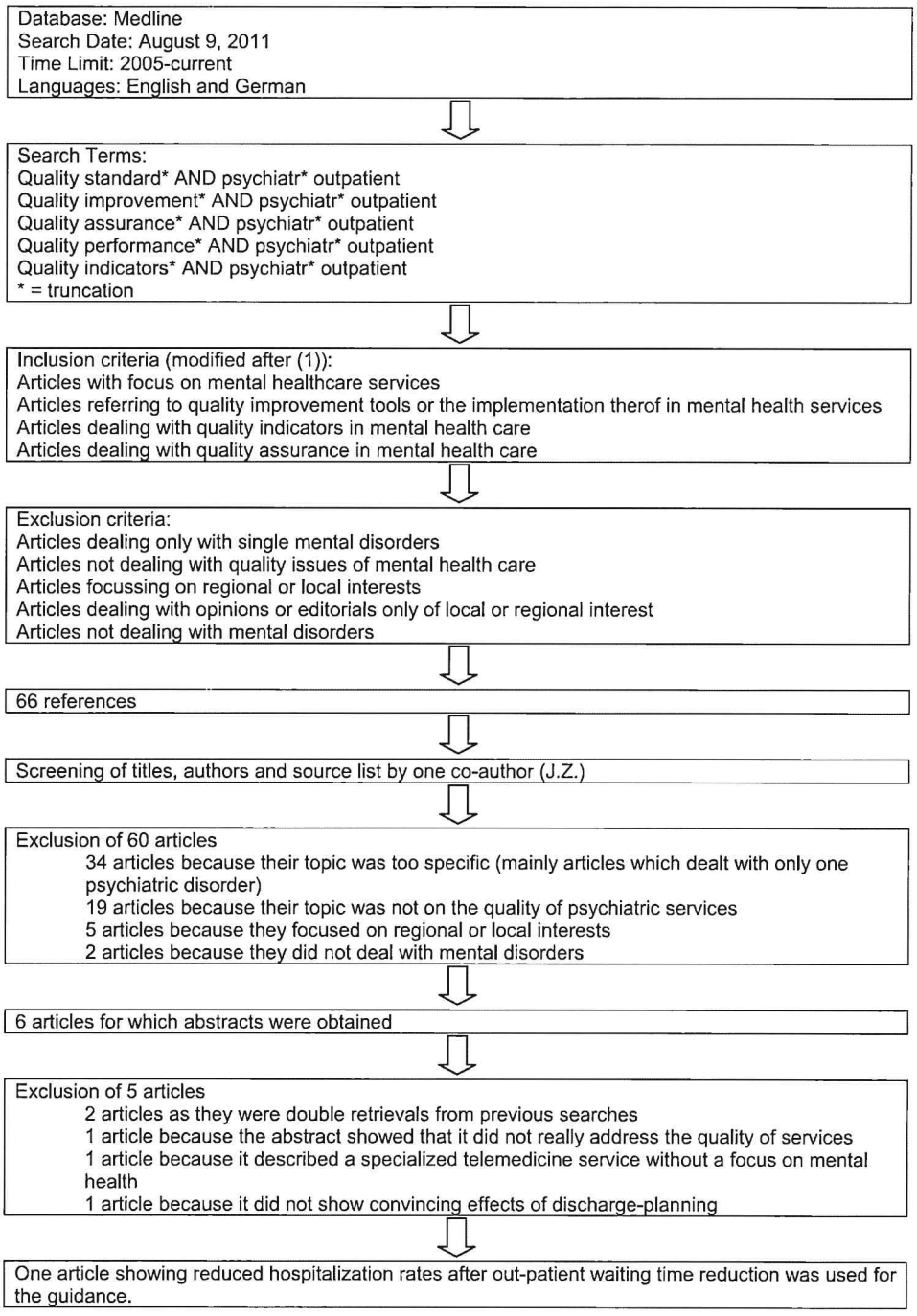

Fig. 4. Flow scheme of literature search specified on out-patient mental healthcare quality assessment studies.

settings, and all mental disorders. This will be the subject of a separate EPA guidance recommendation. Further details about the concept of quality used here are given in Info Box 1.

2.5. Grading of evidence and recommendations

Modified after a systematic review by Weightman et al. [133] for the grading of evidence and recommendations for public health interventions, the evidence retrieved in the literature search was graded following a three-part evidence rating system: +: expert opinion; ++: unsystematic reviews; +++: Cochrane Review or other systematic reviews. A systematic review is a review which predefines search terms and databases, gives details about inclusion and exclusion criteria, and provides details about the number of retrieved, included, and excluded documents, plus a commented list of documents used for the purpose of the systematic review. All other types of reviews are defined here as "unsystematic".

In some cases, single trials were used if no systematic reviews were available and graded instead of reviews, and in these cases, the evidence was graded as follows: +: single uncontrolled study; ++: single controlled, unrandomized study; +++: single controlled, randomized study. The recommendations were graded following a three-part recommendation rating system: *: recommendation

based mainly on expert opinion; **: recommendation based on expert opinion and/or unsystematic reviews and/or single uncontrolled or controlled, but unrandomized studies; ***: recommendation based on Cochrane reviews or other systematic reviews or single controlled, randomized studies.

2.6. Development of quality indicators

To develop quality indicators is a normative process, deciding on the range of values of a consented operational ratio with explicitly defined nominators and denominators based on empirical data. They have been structured as explained in the previous chapters. Quality indicators were developed by the authors of this guidance based on the developed recommendations. Where possible, we used quality indicators provided by the sources of the recommendations. In most cases, quality indicators here are formulated as ratios of nominators and denominators. Usually, the number of services which provide a certain structural or procedural feature is divided by the total number of services. This may then be multiplied by 100, which gives the percentage of services providing a certain feature. Definitions of these quality indicators are given in Table 1.

3. Results

Table 1 summarizes the consented general and setting-specific recommendations for the assessment, assurance and optimisation of structure and process quality of mental health services in Europe, including gradings for evidence and recommendations, additional comments, and source informations.

This table should not be regarded as a "cookbook" for mental health services, but rather as a guide to important aspects when evaluating, developing or managing such services with respect to quality. Note that we have omitted important but rather self-explanatory components like access to fresh air or adequate staffing from the list mainly due to the fact that such elementary quality indicators can be found in generally accessible standards like those published by the Royal College of Psychiatrists (see references in Table 1). Based on the expert consensus and the retrieved evidence, the following 30 recommendations can be given on the following subjects. However, general structure recommendations on the microlevel and specific structure recommendations on both the macro- and mesolevel, as well as general process recommendations on the macrolevel and specific process recommendations on both the macro- and mesolevel cannot be given mainly because of a lack of studies.

3.1. Structure recommendations

3.1.1. General structure recommendations

3.1.1.1. Macrolevel recommendations.

3.1.1.1.1. Recommendation 1: Mental health education. Provide coordinating bodies (e.g., committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders.

This recommendation is based on the WHO-AIMS Version 2.2. [143] and ensures that mental health policies are coordinated, which appears to be an important aspect to the developers of this guidance given the beformentioned mix of service structures found in European countries. The second part of the recommendation ensures that public education on mental disorders becomes a topic of awareness campaigns, which is important to ascertain that the public knows about the typical signs, symptoms and treatment opportunities for mental disorders. This recommendation is expert opinion-based since we could not identify studies showing that such coordinating bodies or awareness campaigns lead to improved detection or better treatment of people with mental disorders.

3.1.1.1.2. Recommendation 2: Mental health reporting and monitoring. Install mental health information systems to monitor the epidemiology of mental disorders and data on the number of mental healthcare facilities, their regional distribution, frequency and type of use, staffing, and mental health research. The items mentioned in this recommendation are derived from the respective chapter (domain 6) in the WHO-AIMS Version 2.2. [143]. They are important for providing sufficient and even access to mental health services, and in order to ascertain progress in mental health research. These are the core features of mental healthcare systems–according to the opinion of the authors of this guidance – and need to be monitored and ascertained. This is an expert opinion because studies withholding such key tenets of mental healthcare in a systematized fashion would be unethical.

3.1.1.2. Mesolevel recommendations.

3.1.1.2.1. Recommendation 3: Structural requirements to ascertain patients' dignity and basic needs. Implement the ITHACA Toolkit items to ascertain that the structural requirements of in- and outpatient mental healthcare facilities are met for the fulfilment of patients' basic needs, and to ascertain that patients' dignity and human rights are observed at all times. This general structure recommendation uses the ITHACA Tookit [72], which provides a compilation of 30 sections for monitoring human rights in mental health and socal care institutions, and which is partly overlapping with corresponding recommendations in the Royal College of Psychiatrist assessment of psychiatric wards [30], and the Finnish Quality Recommendations for Mental Health Services [104]. Ascertaining human rights and the basic needs of people with mental disorders is of prime importance on the service structure level and was therefore chosen as the first recommendation on the mesolevel. Similar to recommendation 2, it would be unethical to withhold such basic rights in putative controlled studies on this subject matter, therefore the recommendation can only be on the expert level.

3.1.1.2.2. Recommendation 4: Multiprofessionality of services. Assemble multiprofessional teams with competences in social occupational-, work- and housing-related service provision. Multiprofessional teams caring for people with mental disorders are efficient, based on the evidence showing that community mental health teams, assertive community treatment teams and other types of intensive case management are efficient [reviewed by 43, 53, 97]. However, no study has formally shown that the multiprofessionality is superior to uniprofessionality, simply because such studies would ethically unfeasible and impractical. Therefore, this recommendation is based on both expert opinion and Cochrane review of international systematic studies on multiprofessional services. Following conclusions in [52], such multiprofessional teams should include a psychiatrist within an interdisciplinary team comprised of medical and social professions.

3.1.1.2.3. Recommendation 5: Access to good primary mental healthcare and specialised psychiatric care. Provide access to good primary care for mental health problems by developing primary care services with the capacity to detect and treat mental health problems, and create centres of competence and promote networks in each region; ensure access to specialised psychiatric services for those in need. Primary care here is defined as a form of healthcare which is the primary contact point of help-seeking persons. "Access" here is defined as a timely appointment for every person with a mental disorder who is in need of specialised psychiatric services. The rationale for this recommendation is the individualisation of treatment provision in that both basic and

Table 1
EPA guidance on quality of mental health services – evidence base and recommendations.

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
General structure recommendations					
Macrolevel recommendations					
Recommendation 1: Mental health education	Provide coordinating bodies (e.g., committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders*	WHO Assessment Instrument for Mental Health Systems*	Number of coordination bodies (e.g., committees, boards, offices that coordinate and oversee public education and awareness campaigns on mental health and mental disorders) per 100,000 population	Summarised recommendation derived from Items 5.1.1 in [143]: "Existence of coordinating bodies (e.g. committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders"	[143] (WHO-AIMS Version 2.2.)**
Recommendation 2: Mental health reporting and monitoring	Install mental health information systems to monitor the epidemiology of mental disorders and data on the number of mental healthcare facilities, their regional distribution, frequency and type of use, staffing, and mental health research*	WHO Assessment Instrument for Mental Health Systems*	Presence of a mental health information system providing annually updated information of the number of mental healthcare facilities, their regional distribution, their staffing and use (numbers of patients per diagnosis per year and per service)	Summarised recommendation derived from Domain 6 in [143]: items include that there is a formally defined list of individual data items that ought to be collected, that there is a proportion of mental hospitals, community-based psychiatric in-patient units, and mental health out-patient facilities routinely collecting and compiling data by type of information, that there is a proportion of mental health facilities from which the government health department received data in the last year, that there is a report covering mental health data by the government health department in the last year, that there is monitoring of the mental health professionals working in mental health services who have been involved as researchers in the last five years	[143] (WHO-AIMS Version 2.2.)**
Mesolevel Recommendations					
Recommendation 3: Structural requirements to ascertain patients' dignity and basic needs	Follow the requirements of the ITHACA Toolkit items to ascertain that the structural requirements of in- and out-patient mental healthcare facilities are met for the fulfilment of patients' basic needs, and to ascertain that patients' dignity and human rights are observed at all times[1]	Expert opinion*	Number of mental healthcare facilities following the ITHACA toolkit recommendations divided by the number of mental healthcare facilities not following the ITHACA toolkit recommendations	The Ithaca toolkit provides a compilation of 30 sections for monitoring human rights in mental health and social care institutions with many recommendations similar to the recommendations by the Royal College of Psychiatrists for acute psychiatric wards [30]. This recommendation corresponds with recommendation 1 of the Finnish Quality Recommendations for Mental Health Services [72]	[72] (ITHACA Toolkit)[d], [104]
Recommendation 4: Multiprofessionality of services	Assemble multiprofessional teams with competences in social occupational-, work- and housing-related service provision***	Expert opinion based on a metareview and Cochrane reviews of international studies***	Number of multiprofessional teams per 100,000 people with mental disorders	Recommendation in agreement with similar recommendation in the conclusion chapter of [52] and evidence for the efficiency of community mental health teams, assertive community treatment and other types of intensive case management usually involving multiprofessional teams [43,97]	[43,52,97]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 5: Access to good primary mental healthcare and specialised psychiatric care	Provide access to good primary care for mental health problems by developing primary care services with the capacity to detect and treat mental health problems, and create centres of competence and promote networks in each region; ensure access to specialised psychiatric services for those in need*	Expert opinion*	Number of primary mental health services. Korrigiert per 100,000 people with mental disorders Number of competence centres for psychiatry per 100,000 people with mental disorders Competence centers for the purpose of this guidance are those centers which health professionals, service users, carers and the media can contact for advice on the management of mental disorders	Structural recommendation in recommendation 6 on the need for good primary care for mental health problems ("Ensure that all people have good access to mental health services in primary care setting", "Create centers of competence and promote networks in each region which health professionals, service users, carer and the media can contact for advice.", "Design and implement treatment and referral protocols in primary care establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services") [140] This recommendation corresponds with recommendations 3 and 7 of the Finnish Quality Recommendations for Mental Health Services [104]	[140] (Mental Health Action Plan for Europe, WHO Europe, 2005)[c], [104]
Recommendation 6: Availability of technological equipment for assessment and treatment	Provide all state of the art evidence-based technological diagnostic and therapeutic equipment and services to help-seekers within 72 hours for non-acute cases and immediate access for acute cases*	Expert opinion*	Number of in- and out-patient services which provide access to major evidence-based diagnostic and therapeutic technologies within 72 hours for non-acute cases and immediate access for acute cases divided by the number of in- and out-patient services without such a provision ECG Chest X-ray Laboratory tests EEG MRI CT Electroconvulsive therapy	Developed by authors	Expert opinion
Recommendation 7: Psychiatric workforce	Create a sufficient and competent workforce ensuring an equitable distribution and develop specialist training streams*	Expert opinion*	Number of psychiatrists in out-patient psychiatric services per 100,000 people with mental disorders Number of psychiatrists in hospitals per 100,000 people with mental disorders	Structural recommendation in recommendation 9 ("Create a sufficient and competent workforce") [140] This recommendation corresponds with recommendations 9 and 10 of the Finnish Quality Recommendations for Mental Health Services [104]	[140] (Mental Health Action Plan for Europe, WHO Europe, 2005)[c], [104]
Recommendation 8: Catchment areas	Ensure that catchment areas/ service areas are implemented as a way to organise psychiatric services to communities*	WHO Assessment Instrument for Mental Health Systems*	Number of people living in areas in which catchment areas are defined divided by the number of people living in areas in which no catchment areas were defined	Item 2.1.2 in [143]: "Catchment areas/ service areas exist as a way to organize mental health services to communities"	[143] (WHO-AIMS Version 2.2)[c]*

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 9: Day hospitals for people with acute mental disorders	Develop day hospital services for people with acute mental disorders***	Cochrane review based on nine randomised controlled studies***	Number of "places" in day hospital services for people with acute mental disorders per 100,000 people with acute mental disorders	Caring for people in acute day hospitals can achieve substantial reductions in the number of people needing in-patient care, whilst improving patient outcome. This review only considered studies with acute day hospitals and patient characteristics were not further described. However, the definition of a "day hospital" in the sense of this Cochrane review was "diagnostic and treatment services for acutely ill patients who would otherwise be treated on traditional psychiatric in-patient units" [100]. Therefore, the conclusions from the Cochrane review were formulated by the authors to pertain to "acute mental disorders" for the purposes of this guidance	[100]
Recommendation 10: Psychiatric care for members of minority groups	Provide adequate psychiatric care facilities for linguistic, ethnic and religious minority groups*	WHO Assessment Instrument for Mental Health Systems[t]	Number of linguistic, ethnic and religious minority groups for which specialised mental healthcare services are available divided by the number of linguistic, ethnic and religious minority groups for which specialised mental healthcare services are not available	Summarised recommendation derived from Items 2.11.3-5 [143]: 2.11.3: "Percentage of mental health out-patient facilities that employ a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent" 2.11.4: "Proportionate use of mental health services by ethnic and religious minority groups in comparison to their relative population size" 2.11.5: "Proportionate number of ethnic and religious minority groups admissions to mental hospitals in comparison to their relative population size"	[143] (WHO-AIMS Version 2.2)[c*]
Specific Structure Recommendations					
Microlevel recommendations					
Recommendation 11: Essential in-patient services structural requirements	Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities")[†]	Expert opinion[+]	Number of psychiatric hospitals/ in-patient psychiatric services fulfilling the essential structural requirements outlined as Type 1 recommendations in Part 2 "Staffing" of Section 1 and Section 4 ("Environment and Facilities") as recommender by the Royal College of Psychiatrists AIMS guidance divided by the number of services not fulfilling these requirements Each psychiatric ward is counted as a service unit	General recommendations on staffing and structures of psychiatric wards	[30]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 12: Essential out-patient services structural requirements	Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance for in-patient services (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities")*	Expert opinion*	Number of out-patient services fulfilling the essential structural requirements outlined as Type 1 recommendations in Part 2 "Staffing" of Section 1 and Section 4 ("Environment and Facilities") as recommender by the Royal College of Psychiatrists AIMS guidance divided by the number of services not fulfilling these requirements	General recommendations on staffing and structures of psychiatric wards which may in analogy be used as best practice recommendations for out-patient services	[30]
Recommendation 13: Essential rehabilitation services structural requirements	Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2 "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities")*	Expert opinion*	Number of rehabilitation wards fulfilling the structural requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance (Part 2 "staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities") divided by the total number of rehabilitation units	General recommendations on staffing and structures of psychiatric wards, in which Type 1 recommendations are the essential ones	[31]
Recommendation 14: Community mental health teams for people with severe mental illnesses	Develop a system of community mental health teams for people with severe mental illnesses and disordered personality**	Cochrane review based on three randomised controlled studies***	Number of community mental health teams for people with severe mental illnesses or personality disorders per 100,000 people with severe mental illness or personality disorders	Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. "Personality disorder" was not closer defined in this study, but the term "personality disorder" was used as a search term for the identification of studies of putative relevance for this Cochrane review	[97]
Recommendation 15: Intensive Case Management	Implement Intensive Case Management services for severely mentally ill persons with high hospital use***	Cochrane review of 38 trials***	Number of severely ill persons in Intensive Case Management divided by the total number of severely ill persons	This subgroup of patients benefited from intensive case management (reduced hospitalisations, increased retention in care). "Severe mental illness" was defined using the National Institute of Mental Health criteria (Note by the Authors: this involves a diagnosis of non-organic psychosis or personality disorder, duration characterized as involving "prolonged illness" and "long term treatment" and operationalised as a two-year or longer history of mental illness or treatment, and disability, which includes dangerous or disturbing social behaviour, moderate impairment in work and non-work activities and mild impairment in basic needs), and, in the absence of these criteria, an illness such as schizophrenia, schizophrenia-like disorders, bipolar disorder, depression with psychotic features or/and personality disorder [43]	[43]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 16: Integrated Care Models	Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers**	Expert opinion based on a metareview of international studies**	Number of integrated models of cooperative community care providing evidence-based services with joint budgetary responsibility of participating service providers divided by the sum of the numbers of psychiatric hospitals, psychiatric departments in general hospitals, out-patient mental healthcare services and private psychiatric practices	Recommendation derived from similar recommendations in the conclusion chapter of Ref. [52]	[52]
Process recommendations					
General process recommendations					
Mesolevel recommendations					
Recommendation 17: Evidence-based medicine	Follow the rules of evidence-based medicine in diagnostic and therapeutic decisions**	Systematic reviews and single studies*†	Numbers of mental health services (in- and out-patient) with implemented standard operating procedures ascertaining obedience to the rules of evidence-based medicine divided by the number of mental health services (in- and out-patient) without such implemented standard operating procedures	Reviews and single studies show that following evidence-based medicine guidelines leads to improved outcome	[147]
Microlevel recommendations					
Recommendation 18: Safety issues	Implement operational policies in psychiatric facilities to ascertain patient and staff safety, e.g., with efficient alarm systems, and to manage violent patient behaviour*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of the mental health services (in- and out-patient) with standard operational policies to ascertain patient and staff safety divided by the number of those without such standard operational policies Operational policies defined here for the purpose of this guidance as predefined standard procedures which are used to deal with specific organisational tasks	Recommendations in Numbers 18.1–18.5 (safety), 19.1–19.9, (management of violence), 20.1–20.7 (falls), 21.1–21.3 (pressure ulcer care), 22.1–22.5 (infection control), 23.1–23.2 (management of alcohol and illicit drugs), 24.1–24.7 (safety) and 25.1 (alarm systems)	[30] (Royal College of Psychiatrists)[f]
Recommendation 19: Informed consent	Ascertain that the choice of treatment is made jointly by the patient and the responsible clinician based on an informed consent*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of patients in all mental health services treated with informed consent divided by the number of patients in all mental health services treated without informed consent	Recommendation 37.1 generalized here to apply to all patients in all types of mental health services and not only related to medication decisions: "The choice of medication is made following consultation with the patient and/or carer and the responsible clinician based on an informed discussion of: the relative benefits of the medication; the side-effects; alternatives; the route of administration (which may include consideration of the need for covert medicines administration if medication refusal is an issue)"	[30] (Royal College of Psychiatrists)[f]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 20: Monitoring of physical illness and access to general and specialised medical services	Monitor physical illness and provide timely access to general and specialised medical services when necessary**	WPA recommendation on physical illness in patients with mental disorders and EPA position statement on cardiovascular disease and diabetes in people with severe mental illness (unsystematic reviews)**	Number of patients with mental illness and with physical illness monitoring divided by the total number of patients with mental illness	In correspondence with recommendation 4 at the system level (e.g., population-wide recommendations as contrasted to individual-level actions recommended) [39], to improve access to and care of physical health of people with severe mental illness ("Improve access and care of physical health of the SMI population") SMI = severe mental illness	[36,38,39]
Specific process recommendations Microlevel recommendations					
Recommendation 21: Hospitals/ In-patient Services: basic requirements	Implement the essential process requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS (Section 2 "Timely and Purposeful Admission" and Section 3 "Safety")*	Expert opinion*	Number of patients admitted to mental hospitals and other in-patient services for which Type 1 recommendations of Section 2 ("Timely and Purposeful Admission") and Section 3 ("Safety") are fulfilled divided by the total number of admitted patients	These Type 1 recommendations are essential elements of the general recommendations on staffing and structures of psychiatric wards, which are here focused on timely and purposeful admission and safety aspects as the key elements for providing basic requirements	[30] (Royal College of Psychiatrists)[f]
Recommendation 22: Hospitals/ In-patient Services: admission procedures	Ensure that on the day of their admission to a psychiatric ward, patients receive a basic structured psychiatric and medical assessment*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of patients with mental illness admitted to a psychiatric ward or other in-patient psychiatric service with psychiatric and medical assessment within 24 hours of admission divided by the number of admitted patients with mental illness	Revised recommendation 12.8: "On the day of their admission or as soon as they are well enough, patients receive a basic structured standard medical assessment and this is documented"	[30] (Royal College of Psychiatrists)[f]
Recommendation 23: Hospitals/ In-patient Services: access of wards to special services	Implement access of psychiatric wards to the following services: psychology, occupational therapy, social work, administration, pharmacy*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of the mental hospital and other in-patient units with access to psychology, occupational therapy, social work, administration and pharmacy divided by the total number of mental hospital wards	Recommendation 2.9: "The ward has access to sessional or part-sessional support from the following services: psychology, psychological therapies, occupational therapy, social work, pharmacy, dietetics, speech and language therapy"	[30] (Royal College of Psychiatrists)[f]
Recommendation 24: Hospitals/In-patient Services: detained patients procedures	Give detained patients prompt written information on their rights according to national rules and regulations*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of detained patients with written information on their rights within 12 hours divided by the number of detained patients without such information	Rewritten and generalised recommendation 12.5: "On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of the MHA, given written information on their rights, rights to advocacy and second opinion, right to move hospital, rigt of access to interpreting services, professional roles and responsibilities, and the complaints procedures." MHA = mental health act	[30] (Royal College of Psychiatrists)[f]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 25: Elimination of waiting times for out-patient appointments	Implement processes to eliminate waiting times for out-patient appointments*	Single uncontrolled study*	Number of patients with a waiting time of 0 days divided by the number of patients with a waiting time > 0 days. From the literature, no normative standard for an acceptable maximal waiting time can be derived, because interindividual needs vary widely. The ideal target value should be zero days, since this study tried to eliminate waiting times	Elimination of waiting times for out-patient appointment reduces hospital admissions	[145]
Recommendation 26: Rehabilitation units	Implement the essential process requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance: Part 1 "Policies and Protocols" of Section 1 ("General Standards"); Part 15 "Initial Assessment and Care Planning", of Section 4 ("Timely and Purposeful Admission"), and Section 3 ("Safety")*	Expert opinion*	Number of psychiatric rehabilitation wards which fulfil all Type 1 recommendations of the Royal College of Psychiatrists AIMS guidance in Part 1 ("Policies and Protocols") of Section 1 ("General Sandards"), Part 15 ("Initial Assessment and Care Planning"), of Section 4 ("Timely and Purposeful Admission"), and Section 3 ("Safety") divided by the number of psychiatric rehabilitation wards	General recommendations on staffing and structures of rehabilitation in-patient units	[31]
Recommendation 27: Effective components of home-based treatment	Implement the effective process components of home treatment teams: small case load, regular visits at home, high percentage of contacts at home, responsibility for health and social care**	Cochrane search and expert opinion**	Number of mental healthcare facilities providing home treatment and follow a plan for regularly visiting at home, achieve at least a 50% rate of contacts at home,have responsibility for health and social care, and have small case loads of less than 50 patients per case manager, divided by those mental healthcare facilities providing home treatment and not fulfilling at least one of these requirements Explanatory note: "Responsibility for health and social care" means that responsibility for healthcare and social care rest within the same multidisciplinary team [21]	This indicator assesses whether home treatment services implement effective process components as identified in [21]. Note that the contact rate of 50% and the case load of 50 cases per case manager were chosen as expert opinions since there are no studies proving the efficacy or non-efficacy of home treatment for services not meeting a certain contact rate or with higher or lower numbers of cases per case manager. The studies show associations between case load and outcome and between high percentages of contact at home and outcome. Based on an analysis of the efficiency of assertive community treatment and other types of home-based treatment [21], the authors had shown that results varied widely giving an inconclusive picture. Therefore, this review set out to define the active components across the different home-based services and found that these two components were significantly associated with a reduction in hospitalization	[21]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 28: Essential components of community mental health treatment	Implement the essential components of community mental health treatment: Multidisciplinary patient assessment, regular team reviews, monitoring and prescribing medication, psychological interventions, focus on continuity of care*	Cochrane review and expert opinion**	Number of persons in community mental healthcare who receive all of the following: multidisciplinary assessment, regular team reviews, monitoring and prescribing medication, psychological interventions and whose management plan has a focus on the continuity of care, divided by the number of all persons in community mental healthcare	These are the elements characteristic of community mental healthcare teams. Although there are no studies showing that high fidelity to these elements is significantly effective, the lack of studies pertaining to this question makes only an expert opinion available based on current practice	[97]
Recommendation 29: Active components of intensive case management	Implement the known active components of intensive case management, if intensive case management is used***	Cochrane review of 38 trials***	Combined index of the subscales "team membership" and "team structure organisation" of the Index of Fidelity to Assertive Community Treatment. As there is just a general correlation between this index and outcome, no cutoff can be given here	Model fidelity was associated with decreased hospital times	[43]
Recommendation 30: Organisational integration of psychiatric in-patient and out-patient services	Organisationally integrate psychiatric hospitals or psychiatric departments in general hospitals with psychiatric out-patient facilities including out-patient facilities in psychiatric hospitals, private practices and other ambulatory mental health services*	WHO Assessment Instrument for Mental Health Systems*	Number of mental hospitals organisationally integrated with mental health out-patient facilities divided by the total number of mental hospitals	Item 2.1.3: "Proportion of mental hospitals organisationally integrated with mental health out-patient facilities"	[143] (WHO-AIMS Version 2.2.)[c]

Although WHO-AIMS was mainly developed as an assessment instrument for middle- and low-income countries [118], it provides a range of indicators that appear also useful for European high-income countries, and these were transposed into recommendations for the European Guidance.

[a] The recommendations developed by the authors of this paper were graded following a three-part recommendation rating system: *: recommendation based mainly on expert opinion; **: recommendation based on expert opinion and/or unsystematic reviews and/or single uncontrolled or controlled, but unrandomized studies; ***: recommendation based on Cochrane reviews or other systematic reviews or single controlled, randomized studies.

[b] The evidence retrieved in the literature search was graded following a three-part evidence rating system: +: expert opinion; ++: unsystematic reviews; +++: Cochrane Review or other systematic reviews. A systematic review is a review which predefines search terms and databases, gives details about inclusion and exclusion criteria, and provides details about the number of retrieved, included, and excluded documents, plus a commented list of documents used for the purpose of the systematic review. All other types of reviews are defined here as "unsystematic". In recommendations where single trials were used as the best available evidence source, the evidence was graded as follows: +: single uncontrolled study; ++: single controlled, but unrandomized study; +++: single controlled, randomized study.

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

[d] http://www.ithaca-study.eu/outlines.html.

[e] http://www.euro.who.int/__data/assets/pdf_file/0008/96452/E87301.pdf.

[f] http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/aims.aspx. Internet sources c to f, last accessed on August 24, 2010.

specialised mental health services are necessary to cover the needs of all people with mental disorders. This cannot be studied in controlled trials, therefore this recommendation is founded on expert opinion, but it is based on recommendations from the WHO Mental Health Action Plan for Europe [140] and the Finnish Quality Recommendations for Mental Health Services [104].

3.1.1.2.4. Recommendation 6: Availability of technological equipment for assessment and treatment. Provide all state of the art evidence-based technological diagnostic and therapeutic equipment and services within 72 hours. This structural recommendation is based on the clinical experience that a thorough (preferably evidence-based) diagnostic workup in a person with a mental health problem may require a range of technical investigations. The time limit of 72 hours will be considered sufficient for non-acute cases. However, in acute cases, immediate referral to specialists providing these services may be required. An important aspect for the general quality of mental health services is whether they can provide access to all necessary diagnostic and therapeutic procedures in time. For instance, medical technologies like biochemical laboratory assessments including drug monitoring, electrocardiography, electroencephalography, neuroimaging (computed tomography, magnetic resonance imaging), or facilities for electroconvulsive treatment, neuropsychological testing, somatic counselling services and experimental-psychological investigations should be provided close to the help-seeking person. We could not identify any systematic studies comparing settings with and without the availability of such technology, and such research would ethically hardly be justifiable. Given the frequent mentioning of such technologies in evidence-based guidelines for the diagnosis and treatment of mental disorders, we felt it necessary to add this item to the guidance list as a prerequisite for any modern mental healthcare service.

3.1.1.2.5. Recommendation 7: Psychiatric Workforce. Create a sufficient and competent workforce ensuring an equitable distribution and develop specialist training streams. This recommendation should not only cover psychiatrists but any number of specialists necessary to supply a sufficient number of services with sufficiently qualified numbers of mental healthcare professionals with an equitable distribution over a region (see also the recommendation on the multiprofessionality of services). The ideal would be a quantitatively sufficient and qualitatively competent workforce depending on the need of the targeted region. This recommendation has an ethical background and was based on a corresponding recommendation by WHO [140] and the Finnish health authorities [104]. A large number of quality indicators could be developed but we focused on the numbers of psychiatrists in in- and out-patient settings per 100,000 people since this guidance mainly aims at optimizing mental healthcare by psychiatrists. Similar indicators may be developed for other professions like psychologists, social workers and nurses in order to ascertain availability and training to support access to adequate multiprofessional mental healthcare (see also Recommendation 4). An important but problematic issue would be the optimal number of psychiatrists or other mental healthcare professionals, which would be expected to be highly variable due to the available mental healthcare framework, the mix of mental healthcare services, the prevalence and incidence of mental disorders and the financial resources. Therefore, we could not give any concrete figures or limits for these quality indicators, but advise to use them in order to detect trends over time which may indicate a deterioration of service qualities if the indicator declines. Other pressing questions are the definitions of "sufficient" and "competent", and we suggest that mental healthcare planners decide on these definitions individually since these are normative concepts whose operationalisations will be highly dependable on the available resources, mental healthcare traditions and societal consensus in every country.

3.1.1.2.6. Recommendation 8: Catchment areas. Ensure that catchment areas/service areas are implemented as a way to organise mental health services to communities. This recommendation is expert opinion-based and follows a corresponding WHO recommendation [143]. This was deemed important for inclusion in the EPA Guidance since it will help to structure and analyse mental healthcare services in a given region also clarifying responsibilities for mental healthcare provision in a given country or area.

3.1.1.2.7. Recommendation 9: Day hospitals for people with acute mental disorders. Develop day hospital services for people with acute mental disorders. This recommendation is based on a Cochrane review [100] and the major sources of evidence were 9 randomized, controlled studies showing that caring for people in acute day hospitals can achieve substantial reductions in the number of people needing in-patient care, whilst improving patient outcome. This review only considered studies with acute day hospitals and patient characteristics were not further described. However, the definition of a "day hospital" in the sense of this Cochrane review was "diagnostic and treatment services for acutely ill patients who would otherwise be treated on traditional psychiatric in-patient units" [100]. Therefore, the conclusions from the Cochrane review were formulated by the authors to pertain to "acute mental disorders" for the purposes of this guidance. Marshall et al. analysed the effects of day hospital versus in-patient care for people with acute psychiatric disorders in their systematic Cochrane review. The conclusion was that acute day hospitals can reduce the number of patients requiring in-patient care and reduce costs. For patients who were judged suitable for day hospital care, the patient data indicated a more rapid improvement in mental state, but not in social functioning amongst people treated in the day hospital. There was no significant difference in readmission rates between day hospitals and controls and while the total hospital day numbers were unchanged, the relative distribution changed towards day hospital days [100] (evidence grade: systematic Cochrane Review). Another Cochrane Review [119] assessed the effects of day hospitals as an alternative to continuing out-patient care for people with schizophrenia and similar severe mental illnesses. The authors stated that day hospitals may help to avoid in-patient care, but they also point out that evidence is limited; there was a lack of some outcome parameters like "quality of life", "satisfaction", "healthy days" and "costs". Data on time spent as in-patient were poorly reported, data regarding allocation rates to hospital care were heterogeneous. There was no difference for loss to follow-up and findings on social functioning were equivocal. There was some indication for a reduction of the rate of unemployment. Different measures of mental state showed no convincing effect (evidence grade: systematic Cochrane review). No information is available as to the process components which are necessary for providing efficient day hospital services. A similar model of mental healthcare is day centre care, but the last Cochrane review found no sufficient studies to assess this type of service coming to the conclusion that pragmatic decisions should be taken if given the choice of using a day centre for mental illness [28]. Therefore, we have not added a recommendation for or against day centres in this guidance.

3.1.1.2.8. Recommendation 10: Psychiatric care for members of minority groups. Provide adequate psychiatric care facilities for linguistic, ethnic and religious minority groups. Given the multiethnicity of the European population and the free exchange of people between European countries, this expert opinion-based recommendation was derived from similar WHO recommendations [143]. It seems important to the developers of the EPA

Guidance since migration backgrounds are now common in a significant ratio of people in Europe and the nature of mental disorders makes it highly advisable to assure that mental healthcare is offered in the mother-tongue of any person affected by a mental disorder. In addition, individual ethnic and religious aspects of a mental disorder need to be respected, which may necessitate certain organisational provisions like special meals or time and space for religious ceremonies in in-patient settings. This, of course, may put a high organisational strain on mental healthcare service providers, but it is inevitable in order to ascertain a high service standard which meets the demands of people with mental disorders.

3.1.2. Specific structure recommendations

3.1.2.1. Microlevel recommendations.

3.1.2.1.1. Recommendation 11: Essential in-patient services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities"). We chose only the Type 1 recommendations, because according to the classification of recommendations in the AIMS guidance [30], failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. Type 2 recommendations are those that an accredited ward would be expected to meet and type 3 recommendations are standards that an excellent ward should meet or standards that are not the direct responsibility of the ward. This expert opinion-based recommendation serves to ascertain a minimum structural quality in selected staffing and facility hardware-centered areas of in-patient mental healthcare. It is based on the recommendation set for psychiatric wards developed by the Royal College of Psychiatrists [30]. We chose the AIMS guidance as our main source because it is available in English, is rather comprehensive and has a high face value. We wanted to be as explicit as possible in our recommendations without overwhelming the EPA Guidance by too many items, therefore we selected "staffing" and "environment and facilities" as the central elements. Other aspects of in-patient treatment covered by the AIMS guidance are dealt with in other recommendations of the EPA Guidance.

International experiences are limited in defining the essential in-patient structural requirements. A working group of Swiss chief psychiatrists agreed on 9 standards for in-patient psychiatric hospitals (these standards include handling critical processes like admission, treatment contract and discharge, dealing with risky situations, involuntary treatment [fixation, isolation, medication], evidence-based treatment, patient satisfaction, interdisciplinary cooperation, handling patient data, appraisal interviews, integrating medico-economical thinking and actions) (evidence grade: expert opinion). These standards can help to build up quality projects or to fulfil external quality requirements like those from EFQM or ISO [135]. The Finnish Mental Health Preparation and Monitoring Group and the UK Royal College of Psychiatrists' Centre for Quality Improvement have published standards for several mental health services in various settings (evidence grade: expert opinion). The patient questionnaires mentioned above and also the standard instruments of the Royal College of Psychiatrists can be recommended for quality assessments of psychiatric hospitals. No evidence-based consensus method to determine the optimal amount of in-patient beds or treatment places could be identified, we have therefore not made any recommendation for this question, and no studies addressed the question which were the effective process components for mental health in-patient services in general. Therefore, we by and large suggested to follow the Royal College of Psychiatrists recommendations for the structure and processes of in-patient mental health services [30] supplemented by the Finnish recommendations [104].

An important question when addressing the issue of structural requirements of in-patient mental health services was how to consider patients' views. A study in Germany aimed to identify aspects of care and treatment which patients considered important, and the degree of patient satisfaction with the services provided. The questionnaire developed for this study covered 22 areas of care and treatment. Patients distinguished between aspects they considered important and aspects they were satisfied with. Areas that were rated as highly important but received low satisfaction ratings included: medication, medical/psychiatric examinations and patient participation in treatment planning. Patient-staff relationships were rated as important and satisfactory. Patient-staff-relationships were also more important for patient satisfaction than the "hotel factor", which includes "ward accommodation" and "quality of food". The authors conclude that the patient survey can be used for quality improvement in psychiatric hospitals (evidence grade: uncontrolled study) [89]. The question remains open how much weight should be given to patients' perceptions and what other evidence should be considered. Gigantesco et al. [58] have also developed and evaluated a self-rating questionnaire for the routine assessment of patients' opinions and experiences of the quality of care in in-patient psychiatric wards. The ROQ-PW questionnaire (Rome Opinion Questionnaire for Psychiatric Wards') includes 10 items. The overall results of the study seem to indicate that this questionnaire is an adequate tool for evaluating patients' opinions on the care provided in in-patient psychiatric wards, which could be slightly modified for use in other settings, such as day centres, residential facilities and day hospitals (evidence grade: uncontrolled study). As it does not involve observer-based assessments, it avoids observer biases.

3.1.2.1.2. Recommendation 12: Essential out-patient services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance for in-patient services (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities"). This is an expert opinion-based recommendation analogous to the corresponding in-patient services recommendation (Recommendation 10). It was developed by the authors of this guidance in order to ascertain that some basic structural requirements are also supplied for the orientation and assessment of mental health out-patient services. Since there was no generic out-patient recommendation available, we suggest to use the applicable AIMS in-patient recommendations in analogy [30]. No comparative suggestions for essential general components of out-patient services are available in Europe. One important factor could be the number of psychiatrists in out-patient services and the number of out-patient mental healthcare facilities, but the necessary numbers depend on a large number of factors like the degree of dehospitalisation in a given country. Therefore, no specific recommendations for the number of in-patient beds and out-patient treatment places, or the optimal mix between these two areas of mental healthcare in a given mental healthcare system, are given here.

3.1.2.1.3. Recommendation 13: Essential rehabilitation services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities"). This is a recommendation analogous to recommendations 11 and 12, but now with a more specific reference to the AIMS guidance developed for in-patient rehabilitation units [31]. The developers of the EPA Guidance think that the same standards used for psychiatric in- and out-patient services should also be applied

to special rehabilitation units and although the AIMS guideline was developed for in-patient rehabilitation units, it may be used in analogy for out-patient rehabilitation units as well. Thus, the rationale for its inclusion is similar as for recommendations 11 and 12. We could not identify specific studies on comparative analyses of different service structures or specific processes in rehabilitation mental healthcare. Certain measures like supported employment or cognitive training are effective in improving rehabilitation outcome especially in schizophrenia and other severe mental illnesses (evidence grade: controlled studies) [15,23,27,44,102]. The components of such complex interventions like supported employment which are most important for therapeutic effects are manifold, but model fidelity appears to play a role and the mental healthcare setting in which these measures are applied is a major factor (evidence grade: systematic review) [15]. The beneficial effects of supported employment are partly dependent on the country in which the method is applied and the generalisability of the beneficial effects of cognitive training to diverse settings and countries remains to be determined. Thus, while it appears reasonable to assume that the structural measures for providing supported employment and cognitive training in mental health rehabilitation should be provided, it appears premature to suggest this as an EPA Guidance. Considering the lack of studies on structure or process effectivity components, we chose to recommend to implement the Royal College of Psychiatrists standards for psychiatric wards (expert opinion recommendations) also for rehabilitation services. These were designed for in-patient rehabilitation units and we could not identify any similarly systematic specific structure or process recommendations for out-patient rehabilitation services.

3.1.2.1.4. Recommendation 14: Community mental health teams for people with severe mental illnesses. Develop a system of community mental health teams for people with severe mental illnesses and disordered personality. This recommendation is based on a Cochrane Review with three randomised controlled studies [97]. Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. "Personality disorder" was not closer defined in this study, but the term "personality disorder" was used as a search term for the identification of studies of putative relevance for this Cochrane review. Especially the Italian experience has provided a wealth of data regarding the efficiency of community-based mental healthcare [6,125]. While substantial reductions in the numbers of hospital care patients have been achieved, community mental health services were established and more frequently used (evidence grade: systematic review) [6]. While residential facilities have been established more or less completely, general hospital psychiatric units are still being added [95]. The spectrum of patients treated in the different facilities and the range of facilities offered shows considerable regional variation even thirty years after the start of the Italian reforms with shortages of public in-patient beds in some regions [35,95]. While the public in-patient sector declined, the private sector remained at the pre-reform level so that the number of private in-patient beds per 10,000 population now exceeds the number of public beds [35]. A major lesson here was that de-institutionalisation can only succeed when the appropriate community mental health services are simultaneously scaled up. From a more general view, the ways of implementing community-based mental health services vary widely between countries prohibiting premature generalisations. A systematic review of community-based care services came to the conclusion that the psychiatric workforce plays a decisive role when outcome variance was to be explained. The presence of a psychiatrist, for example, was considered to be essential for the success of assertive community treatment (ACT) teams. The same applied to staffing levels, the availability of a minimum number of psychiatric beds and the compliance with elementary principles of the ACT service model ("model fidelity") [52] (evidence base: systematic review). The World Psychiatric Association has recently summarized the global experiences of de-institutionalisation in mental healthcare and provided a guidance on steps, obstacles and mistakes to avoid in the implementation of community mental healthcare [130]. Besides financial and organisational aspects, not neglecting mental disorders other than schizophrenia in community mental healthcare and paying due attention to patients' physical health appear as important additional factors to be considered. A new trend is the introduction of compulsory community treatment and involuntary out-patient treatment for people with severe mental disorders. A recent Cochrane review showed that only few studies were available and that this results in no significant difference in service use, social functioning or quality of life compared with standard care, but that people receiving compulsory community treatment were less likely to be victims of crime [80]. Given this small evidence base, we have not formulated guidance recommendations for this special type of out-patient mental health service.

3.1.2.1.5. Recommendation 15: Intensive case management. Implement Intensive Case Management services for severely mentally ill persons with high hospital use. This recommendation is based on a Cochrane review of 38 studies and although the intervention effects seemed weak, the subgroup of severely mentally ill persons benefited from intensive case management (reduced hospitalisations, increased retention in care).

3.1.2.1.6. Recommendation 16: Integrated care models. Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers. This recommendation is derived from the conclusions of a review [52] and based on results from studies and expert opinion.

3.2. Process recommendations

3.2.1. General process recommendations

3.2.1.1. Mesolevel recommendations.

3.2.1.1.1. Recommendation 17: Implementation of evidence-based medicine. Follow the rules of evidence-based medicine in diagnostic and therapeutic decisions. This recommendation was derived from a review and single studies (summarized in [147]). This summary was focused on guideline implementation and although the evidence base is small, this is the best evidence that is available and therefore this recommendation can be made in general.

3.2.1.2. Microlevel recommendations.

3.2.1.2.1. Recommendation 18: Safety procedures. Implement operational policies in mental health facilities to ascertain patient and staff safety, e.g., with efficient alarm systems, and to manage violent patient behaviour. This recommendation is based on expert opinion following the Royal College of Psychiatrists AIMS recommendation [30]. It was included because it addresses an important issue in mental healthcare and although no studies are available, active management of such problematic situations seems the best evidence-based practice. The prevention of deep vein thrombosis, for example, is important for secluded or restrained patients with mental illnesses and it is essential to establish a detailed management plan on seclusion and fixation taking into account the medical risks of physical restraint [37]. The AIMS recommendation also includes suggestions on how to deal with critical situations like the necessity for restraint, with a

special emphasis on those persons with medical conditions which may increase the likelihood of injury during periods of restraint (recommendations 12.10 and 20.6 in [30]).

3.2.1.2.2. Recommendation 19: Informed consent. Ascertain that the choice of treatment is made jointly by the patient and the responsible clinician based on an informed consent. This expert opinion-based recommendation was derived from a medication-related AIMS recommendation [30] and generalized to include all treatment decisions – not just medication decisions.

3.2.1.2.3. Recommendation 20: Monitoring of physical illness and access to general and specialised medical services. Monitor physical illness and provide timely access to general and specialised medical services when necessary. This recommendation is based on expert opinion and on studies indicating the high prevalence of physical illness in persons with mental disorders [36,38,39].

3.2.2. Specific process recommendations

3.2.2.1. Microlevel recommendations.

3.2.2.1.1. Recommendation 21: Hospitals/in-patient services: basic requirements. Implement the essential process requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS (Section 2 "Timely and Purposeful Admission" and Section 3 "Safety") [30]. This expert opinion-based recommendation serves to ascertain that in two essential elements of in-patient processes, namely admission procedures and safety, basic requirements are met.

3.2.2.1.2. Recommendation 22: Hospitals/in-patient services: admission procedures. Ensure that on the day of their admission to a psychiatric ward, patients receive a basic structured psychiatric and medical assessment. This recommendation follows a similar recommendation in the AIMS guidance [30] and is based on expert opinion. It has a high face validity and its fulfilment needs to be ascertained since it is essential to in-patient services quality. A question that we also addressed was the necessary length of hospital stays. A Cochrane review by Alwan et al. [5] had identified six randomized trials comparing the effects of long vs. short stays and that the persons with short stays were more likely to be employed. However, given the lack of systematic studies and the large intra- and interindividual variability of the presumed optimal length of stay, we did not include any recommendation as to the necessary duration.

3.2.2.1.3. Recommendation 23: Hospitals/in-patient services: access of wards to special services. Implement access of psychiatric wards to the following services: psychology, occupational therapy, social work, administration, pharmacy. This expert opinion-based recommendation was developed following a similar AIMS recommendation [30] and reflects the necessity of multiprofessional service provision of people with mental disorders.

3.2.2.1.4. Recommendation 24: Hospitals/in-patient services: detained patients procedures. Give detained patients prompt-written information on their rights according to national rules and regulations. This expert opinion-based recommendation was developed following a similar AIMS recommendation [30] and shall assure that in this very sensitive therapeutic setting, essential legal standards are adhered to.

3.2.2.1.5. Recommendation 25: Elimination of waiting times for out-patient appointments. Implement processes to eliminate waiting times for out-patient appointments. Although this recommendation is evidence based from only a single uncontrolled study [145], it provides quality assurance for a very important field dealing with the continuity and accessability of mental healthcare.

3.2.2.1.6. Recommendation 26: Rehabilitation units. Implement the essential process requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance: Part 1 "Policies and Protocols" of Section 1 ("General Standards"); Part 15 "Initial Assessment and Care Planning" of Section 4 ("Timely and Purposeful Admission") and Section 3 ("Safety"). This is a recommendation serving to ascertain that basic process requirements are met in rehabilitation service units. It is expert opinion-based [31] and provides a selection of essential requirements out of a larger and more comprehensive list.

3.2.2.1.7. Recommendation 27: Effective components of home-based treatment. Implementation of the effective process components of home treatment teams are included: small case load, regular visits at home, high percentage of contacts at home, responsibility for health and social care. This indicator assesses whether home-treatment services implement effective process components as identified in [21]. The studies show associations between case load and outcome and between high percentages of contact at home and outcome. Based on an analysis of the efficiency of assertive community treatment and other types of home-based treatment, it was shown that results varied widely giving an inconclusive picture. A recent Cochrane review dealing with home crisis intervention came to the conclusion that home care leads to a reduction of repeated hospital admissions, reduces loss to follow-up and reduces family burden, and increases patient and relatives satisfaction, but that more evaluative studies were needed [76]. No effects on mental state or mortality were found. For older people with mental health problems, a systematic review by Toot et al. [131] came to the conclusion that crisis resolution/home treatment teams were effective in reducing the number of hospital admissions, but that evidence was inadequate for drawing conclusions about length of hospital stay and maintenance of community residence. A randomized controlled trial concluded that mobile crisis team intervention to enhance linkage of suicidal emergency department patients to out-patient psychiatric services had no positive effects on patient-relevant outcomes although it increased the contact rate [35]. The evaluation of home-based mental healthcare services is made difficult due to the large variation of the kinds of services provided [20]. Burns et al., however, identified the following six components as the effective ingredients of home-based care for mental illness based on a Cochrane search: smaller case loads, regularly visiting at home, a high percentage of contacts at home, responsibility for health and social care, multidisciplinary teams and a psychiatrist integrated in the team [21]. These were chosen as structural or process recommendations as appropriate.

3.2.2.1.8. Recommendation 28: Essential components of community mental health treatment. Implement the essential components of community mental health treatment. If implemented, community mental health treatment should include effective elements. This includes the following process elements: multidisciplinary patient assessment, regular team reviews, monitoring and prescribing medication, psychological interventions, focus on continuity of care. As a conclusion of 6 controlled studies from England, Australia and Canada, community mental health teams had no added effect on psychiatric symptoms. Admissions to hospitals were possibly lower. Social adjustment and patient satisfaction levels were better [52]. Malone et al. [97] evaluated the effects of community mental health teams for people with serious mental illnesses versus non-team standard care (evidence base: systematic Cochrane review). They concluded that community mental health teams were superior in promoting greater acceptance of treatment and may be superior in reducing hospital admission and avoiding death by suicide. As aforementioned, the WPA guidance discusses this issue in more detail [96,130]. For the EPA guidance recommendation, the positive effects on treatment acceptance suggest the usefulness of implementing CMHT services and to include the following process elements: multidisciplinary patient assessment, regular team reviews, monitoring and prescribing medication, psychological interventions, focus on continuity of care. These are the elements characteristic of CMT teams. Although

there are no studies showing that high fidelity to these elements is significantly effective, the lack of studies pertaining to this question makes only an expert opinion available based on current practice [100].

3.2.2.1.9. Recommendation 29: Active components of intensive case management. Implement the known active components of intensive case management, if intensive case management is used. If implemented, intensive case management should follow the rules outlined by assertive community treatment procedures. This recommendation is based on a Cochrane review of 38 studies showing that model fidelity was associated with reduced hospital times [43]. The available evidence suggests that intensive case management is most effective to reduce the numbers of days in psychiatric hospitals in the most severely affected people with mental illness with high-frequency use of mental health services [23] (evidence base: systematic review). There was a global positive effect on social functioning. The effects on mental state and quality of life, however, remained uncertain. Intensive Case Management seems to be most effective in those with a severe mental illness with high levels of hospitalisation rates and in those who receive this service in a setting with high fidelity to the original service construct. Marshall identified several critical issues in that terminology in this field was often confusing and that the adherence to the definitions of complex interventions was of central importance. Also, the choice of control group was very decisive for the net effect of such complex interventions, a problem which makes meta-analyses inherently difficult. Similarly, Burns et al. reported that European studies on intensive case management failed to replicate the highly significant advantages over standard care demonstrated in early American and Australian work [19]. In the EPA guidance, intensive case management is therefore only recommended for those with severe mental illness and high hospital use (structure recommendation), and a high degree of model fidelity to standardised model constructs like assertive community treatment or case management is necessary. A recent controlled trial concluded that assertive community treatment was effective for improving one-year outcome in schizophrenia patients [88] (evidence base: controlled study). Interventions in this class of mental health services were assessed in a recent Cochrane review by Dieterich et al. [43] with the main result that such services reduced hospitalisations compared to standard care, increased retention in care and reduced loss to follow-up. The results on mental state outcomes were considered equivocal. Mortality or suicidality were not changed compared to standard care. Social functioning results varied and data for quality of life were weak and inconclusive. A close adherence to the assertive community treatment model appeared to benefit the outcome "decreasing times in hospital", which was most pronounced in services with a high baseline hospital use rate in the population. In summary, Dieterich et al. [43] concluded that intensive case management was effective in improving process variables, but less so – if any – outcome variables. The conclusion for this guidance is to suggest the implementation of such services only for severely ill persons with high hospital use (structure recommendation) and to suggest to use model fidelity as a process recommendation.

While preadmission out-patient care appears to lead to reduce hospital stay times [33] (evidence base: observational study in different settings with and without preadmission out-patient care) and seems to be a quality indicator which may be dealt with by a case manager, it is questionable in how far the number of readmissions is a quality indicator for the mental healthcare system as a whole, but readmission frequency appears to be a quality indicator of the previous hospitalisation [24] (evidence base: naturalistic retrospective analysis) and there is only limited information on how to prevent readmissions [47]. Meta-analyses came to similar, but in some parts contradictory results (especially regarding the efficacy of case management to reduce symptom scores) [23,122,150].

3.2.2.1.10. Recommendation 30: Organisational integration of psychiatric in-patient and out-patient services. Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers. This recommendation is based on a conclusion from a review, which, however, also implied expert consensus [52]. Generally, the integration of mental health services is considered to be important [52], and a recent review came to the conclusion that integrated care models could improve outcome compared with conventional services [50] (evidence base: systematic review). However, only improving access does not automatically improve outcomes in integrated care models as shown in a randomized controlled study for mental healthcare in older patients from minority groups [7]. Regarding care pathways, there is relatively little published in relation to mental health [49]. Mainly based on recommendations in [52] (evidence base: systematic review), we here suggest to develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers (structure recommendation) and to organisationally integrate mental health hospitals with mental health out-patient facilities (based on an expert opinion-based WHO-AIMS recommendation).

4. Conclusions and perspectives

The main intention of this guidance is to promote the optimisation of mental healthcare service structures in Europe. There is a need to investigate the relationship between particular components and contents of mental health services and outcome, in order to increase the knowledge of what is effective in improving mental health and to provide cost-effective measures in mental health services [64].

When reviewing the available studies, we noticed that some areas like "acute day hospitals" were much researched, but are not very common across Europe, while essential questions like whether electroconvulsive treatment as one of the "state of the art" treatments is available have only begun to become the object of systematic studies. Thus, there is a certain discrepancy between the large diversity of mental health service structures that have evolved in Europe and the objects of mental healthcare research, which – as we strived to develop evidence-based recommendations – is also reflected in our recommendations. The recommendations may therefore unjustly privilege mental healthcare structures like home-based treatment, assertive community treatment or day hospitals although an immediate transfer to European countries other than those in which these services have been studied may neither be feasible nor warranted. This limitation clearly underscores our point that these recommendations are not cookbook prescriptions for mental healthcare planning, but rather a reflection of the current state of the art, which needs to be critically assessed for every European country. Pan-European studies comparing different models of mental healthcare services are necessary to further develop European recommendations for mental healthcare. These recommendations cannot be a master plan for mental health services planning, but may provide an initial panel of recommendations, which will now need to be tested in the European countries. As quality indicators are also given here, we recommend to establish a European study group which will assess whether the implementation of these recommendations leads to optimized mental healthcare. Another aspect was that for some essential structural components like the

necessary number of psychiatric beds in a certain region, no evidence-based figures are available. In Germany, for example, this number is determined by the Hill-Burton formula, which is based on the US-American Hill Burton Act of 1946. This Act set standards for the number of hospital beds if federal funding was to be allocated to a certain provider. Later, it became useful to determine the number of beds in psychiatric hospitals. However, it is more of a guidance for political decisions in the mental healthcare market rather than an evidence-based guideline, and does not help individual psychiatric hospitals to determine the number of beds needed. Its formulation according to the German Hospital Association [57] is:

$$\mathrm{HBF} = \frac{\mathrm{E} \times \mathrm{KH} \times \mathrm{VD} \times 100}{\mathrm{BN} \times 1000 \times 365}$$

HBF ("Hill Burton Formula") is the number of beds needed for a given population with E as the population number. KH is the number of hospital cases multiplied with 1000 and divided by E, VD is the average number of hospital days per case and BN is the degree of bed occupancy in percent.The complexity and diversity of the mental healthcare systems and structures in European countries makes it difficult to compare them. We tried to overcome this problem by formulating general principles but avoiding too specific recommendations. Some mental healthcare service structure analyses are only published in the local language, which limits access in other countries. They also often lack strict methodological criteria. We focussed on English and German language papers which introduces language bias to our study, but reviewing all European mental healthcare systems was beyond the scope of this project. It now appears necessary to also review the current mental healthcare systems and identify studies which may have been published in local languages only with a view to adapt additional recommendations. Furthermore, such a study should identify areas of mental healthcare research which would be feasible in the pan-European setting and could become a task of the EPA. Attitudes in society at large towards mental ill-health need to be taken into consideration when assessing mental healthcare structures [117]. These will influence policy makers and therefore an EPA-guided survey of these attitudes would additionally be necessary. One also needs to take into consideration that there are new trends in some European countries away from the all-encompassing, transsectoral community social psychiatric models introducing a new focus on expert psychiatric clinics like clinics for affective disorders, suicide prevention clinics, clinics for treatment refractory schizophrenia etc., linked to both psychiatric intensive beds in wards of general hospitals and outreach teams for chronic patients, with less participation of psychiatrists in assertive community treatment teams [108]. While there is some evidence suggesting a link between the numbers of treated patients and the achievable quality of mental healthcare, these interrelationships are not yet clear and are in need of further study [46]. These developments will make timely updates of the EPA guidance necessary warranting a continuous updating process to be initiated by EPA. Measures should be developed to provide standard tools to assess the efficacy and efficiency of mental health services. Currently, measures of the "content of care" are being developed, e.g., measures to assess whether a person affected by a mental disorder receives the needed social, psychological and physical/pharmaceutical interventions, and if general care organisation is adequate [97,99]. Future updates of this recommendation may need to include such measures once more data on their use become available.There is a pressing need for high-quality, multinational mental healthcare research studies to identify the most effective components of mental healthcare and the EPA is strongly advised to initiate such European research initiatives. The EPA guidance project can be an important step in this direction by providing an overview over the – quantitatively and qualitatively somewhat limited – evidence. International studies are needed which address the issue of the most effective components of mental health service structures and processes with a view to obtain a more solid evidence base for any recommendations about mental health services in Europe. There are only few studies which analyse the impact of mental healthcare structural parameters on patient outcomes. Also, patient outcome is inevitably influenced both by structure quality and process quality. While processes and structures are generally taken as important areas of quality assurance, assessing the outcome of mental healthcare is a third important area and is often used as a readout of the effects of implementing quality assurance measures in mental healthcare structures and processes [42]. However, there is a scarcity of studies relating outcome to structures, while there is a large number of studies assessing the outcomes of specific therapeutic processes. The latter, however, have only limited usefulness for general guidance recommendation pertinent to all European countries and all psychiatric disorders. Still, improving the structures of mental health services may have "downward" effects on processes and outcome [63]. We addressed this complex interrelationship by structuring the recommendations accordingly hoping to clarify which parts of the mental healthcare system are addressed by every individual recommendation.The interventions relevant to mental healthcare structures and processes reviewed in this guidance are mainly of the psychosocial type and do not deal with isolated interventions, with some notable exceptions like the EQOLISE study to assess the efficacy of supported employment [22]. We were challenged by the fact that no standardized assessment procedure was available for interventions like reducing waiting times in out-patient settings or introducing complex service structures or service processes like day hospitals or community mental health teams. We regard the suggestions on the grading of evidence of public health interventions published by a NICE committee as a good starting point for the development of our recommendation grading and evidence rating system [133], and attempt to solve this problem by devising a rating/grading system adapted to the purposes of the EPA guidance recommendations. The generalisability of some recommendations may be highly questionable and will have to be assessed for every European country. The EQOLISE study on supported employment was one of the European multinational mental healthcare studies identified here and showed clear differences of the results in different European countries, which seem to be dependent on the baseline unemployment rate and the social services available besides the intervention method [22]. An important aspect is the comparator in any studies dealing with the effects of novel mental healthcare methods. If "care as usual" is used, context-dependent factors will severely limit the generalisability of any research results. Large-scale international studies are warranted to provide evidence that can be used for developing European recommendations. Therefore, critically assessing the transferability of any study results and resulting recommendations to individual countries must become the task for a future update and the truly pan-European expert panel to be included then. Psychiatry as a medical specialty is constantly undergoing changes following scientific progress which bears upon psychiatric diagnostic or therapeutic procedures. An important current trend that follows from the progress in neurobiology and psychology is to centre psychiatric diagnosis and treatment on the assessment of brain-behavioural functions and their disturbances in mental disorders ("modular psychiatry"; [54]). Neurobiological and psychological models inform psychiatric treatment and recent progress in the psychotherapy of psychotic symptoms is based on such information from

neurobiology and psychology [56]. Such processes will make more sophisticated diagnostic and therapeutic procedures possible. Introducing sub-specialisations may lead to differentiated training programs for those medical students and residents who are more interested in the social psychiatric community-based approach, and more specialised training programs for those becoming high-level psychiatric specialists working in psychiatric expertise medical centers. This could also be a way to attract more medical students into psychiatry as a medical specialty and a medical career. The World Psychiatric Association recently compiled a review on the stigmatisation of psychiatry and psychiatrists, and ways to overcome them [117]. Sharpening the profile of psychiatry as a medical specialty and implementing structures of mental healthcare that foster a medical approach may be important to recruit more highly motivated medical students into the field [108]. Continuous updates of the EPA Guidance will be useful to consider future demographic changes and neuroscientific advances pertinent to mental healthcare. In conclusion, we suggest 30 recommendations for the quality of mental healthcare services accompanied by a corresponding set of quality indicators to assess the degree of implementation of these recommendations. In perspective, with the support of continuous updates, the recommendations will hopefully advance the development of optimal mental healthcare services in Europe in the short and long-term future.

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Original article

EPA guidance on the quality of mental health services

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ABSTRACT

The main aim of this guidance of the European Psychiatric Association is to provide evidence-based recommendations on the quality of mental health services in Europe. The recommendations were derived from a systematic search of the best available evidence in the scientific literature, supplemented by information from documents retrieved upon reviewing the identified articles. While most recommendations could be based on empirical studies (although of varying quality), some had to be based on expert opinion alone, but were deemed necessary as well. Another limitation was that the wide variety of service models and service traditions for the mentally ill worldwide often made generalisations difficult. In spite of these limitations, we arrived at 30 recommendations covering structure, process and outcome quality both on a generic and a setting-specific level. Operationalisations for each recommendation with measures to be considered as denominators and numerators are given as well to suggest quality indicators for future benchmarking across European countries. Further pan-European research will need to show whether the implementation of this guidance will lead to improved quality of mental healthcare, and may help to develop useful country-specific cutoffs for the suggested quality indicators.

1. Introduction

1.1. Aims

The main aim of this guidance of the European Psychiatric Association (EPA) is to provide recommendations for optimal structures of mental health services by identifying and evaluating the available evidence including a comparison between the efficacy of different service structures wherever possible. One basic assumption of this review is that such services can be viewed as health technologies which are amenable to quality assessment. This view has been discussed by Goldman et al. [61], who concluded that a conceptual framework for assessing the organisation of services as a healthcare technology focuses the attention on scientific evidence to guide program design and policy development.

Epidemiological studies document the large number of people affected by mental disorders in Europe and worldwide [3,4,110,127,146], leading to estimates of treatment needs [82,101,114]. Addressing the need to provide sufficient and competent mental healthcare globally, the World Health Organisation (WHO) has published a range of background policy documents on mental healthcare [136,137,140,141]. Also, WHO published the WHO Pyramid Framework which aims at (i) optimisation of the service mix; (ii) limits on in-patient facilities; and (iii) an extension of out-patient general hospital and community mental healthcare service provision [141].

1.2. Mental health services: models and trends with an emphasis on recent developments in Europe

Mental healthcare structures in Europe have been the objective of several review issues [8,11,12,34,53,116]. Concerning the issue of an optimal mix of services, solutions may differ from country to country due to service traditions, economic constraints, lack of psychiatric experts or other factors. Therefore, the EPA Guidance on the Quality of Mental Health Services includes some general principles with the aim to guide service development and service optimisation irrespective of certain service structures. As many of

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these general recommendations are based on opinions or clinical experience and not on scientific evidence, we have taken care to explicitly state the sources of our recommendations and their evidence grade.

The European Community and the European Observatory on Health Systems and Policies have provided basic data on mental health service structures in Europe [48,82].

One major issue is the process of de-institutionalisation, which means that in-patient facilities are down-scaled in favour of out-patient facilities. Nowadays, community-based services are widespread in the USA and the United Kingdom (UK), but the range of services they provide varies very much across Europe. In the UK, for example, Johnson et al. [75] identified 131 services alone as alternatives to standard acute psychiatric in-patient facilities. Concerning the process of de-institutionalisation in Germany, the so-called "Psychiatrie-Enquête" of 1975 led to a reduction of psychiatric hospital beds and the establishment of a variety of out-patient mental health services like psychiatric out-patient departments in psychiatric hospitals, psychiatric departments in general hospitals and smaller-size psychiatric departments in general hospitals instead of large-size state hospitals [2]. This process has not come to an end yet and in 1997, the German Association of Psychiatry and Psychotherapy (Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, DGPPN) recommended that out-patient and in-patient services should be provided evenly across Germany, and that mental healthcare should follow the preference for the "least restrictive alternative" [41]. As a possible drawback of de-institutionalisation, there appears to be a general trend of re-institutionalisation (defined as a process of readmitting previously discharged long-term patients with severe mental illness into forms of long-term institutional care) of the mentally ill in Europe with increasing numbers of persons with mental illnesses in forensic services and other institutions of legal detention (the latter is often defined as "transinstitutionalisation", e.g., people with severe mental illness are not admitted to a psychiatric hospital, but into a forensic hospital or other forms of legal detention) [13,70,103,106,107,108,109,111].

Variability between countries is considerable but no factors of supreme importance for determining outcome measures were identifiable [11], which means that there will be no simple answers to the central question of this guidance, e.g., what are the decisive structural and process features mediating the efficacy of mental healthcare services. As a means to assess the number and types of mental health services in Europe on a meso- and macrolevel, the European Service Mapping Schedule [74] was developed and implemented [40].

The large diversity of service structures and the scarcity of evaluation studies make it difficult to formulate an evidence-based EPA Guidance on Quality of Mental Health Services and we addressed this by assembling a panel of psychiatric experts from a range of European countries. Standardised performance measures for mental health services are not yet available, but local solutions are frequently reported [144]. However, European-wide standards are needed to assess the efficacy and efficiency of mental health services. This would involve developing quality indicators of specific structures and processes, similar to the 12 quality indicators used in the OECD assessments [66,67]:

- continuity of care:
  - timely ambulatory follow-up after mental health hospitalisation,
  - continuity of visits after hospitalisation for dual psychiatric/substance related condition,
  - racial/ethnic disparities in mental health follow-up rates,
  - continuity of visits after mental health-related hospitalisation,
  - coordination of care,
  - case management for severe psychiatric disorders;
- treatment:
  - visits during acute phase treatment of depression,
  - hospital readmissions for psychiatric patients,
  - length of treatment for substance-related disorders,
  - use of anticholinergic anti-depressant drugs among elderly patients,
  - continuous anti-depressant medication treatment in acute phase,
  - continuous anti-depressant medication treatment in continuation phase;
- patient outcomes:
  - mortality of persons with severe psychiatric disorders.

2. Methods

2.1. Definitions

See Info Box 1 and Fig. 1) for definitions of "Quality" and related concepts, and see Info Box 2 for definitions of "Mental Healthcare"and "Mental Health Services".

Recommendations and quality indicators were structured following a subdivision into macro-, meso- and microlevels of analysis. Macrolevel recommendations or indicators refer to the provision of structural quality on the global or national mental health system level concerning mental health education and mental health monitoring and addressing questions of the general organisation principles of the mental healthcare system in a given country. The mesolevel recommendations deal with aspects of the internal structure of mental health systems within national mental healthcare systems, e.g., structural requirements to ascertain patient needs and dignity, multiprofessionality of services, access to and regional distributions of mental healthcare units, availability of technologies, the workforce, catchment areas organisation and mental health services for ethnic and other minorities. A further subdivision relates to microlevel recommendations, which guide structures and processes within individual service units on a local level (Info Box 1).

2.2. Guidance development process and area of validity

The EPA decided to develop a series of guidance papers on topics related to mental healthcare (see the accompanying introductory paper by W. Gaebel and H.-J. Möller to this issue of *European Psychiatry*). We performed a systematic literature search detailed further below. The EPA Guidance then used the judgment of psychiatric experts – in this case, the co-authors of this paper – to formulate guidance recommendations. This guidance is thus based on recommendations derived from scientific evidence where possible and based on expert consensus. The area of validity for the guidance recommendations and quality indicators is Europe.

2.3. Process of evidence search

In order to identify the most important studies for the evidence base of this EPA Guidance on Quality of Mental health Services, literature and source searches were performed. We predefined keywords with which we searched these databases and we used specified criteria for assessing the relevance of the retrieved documents. All steps of the retrieval and exclusion procedure were documented and are given in detail here. This follows the group on Quality of Reporting of Meta-Analyses of clinical randomized controlled trials (QUOROM group) statement on the improvement of the quality of reports of meta-analyses of randomised controlled trials [105].

Due to the diversity of search terms and due to the many documents retrieved on initial exploratory searches, we performed

Box 1. Quality

To define "quality" is a normative process, which may lead to generic and specific indicators of quality. To implement quality management procedures, it is important to know what is measured and what is necessary to transform the current state to the desired state. Quality will therefore be defined in the areas of structures and processes, which may be optimized. Generic aspects of quality will apply to all mental healthcare, while special aspects will apply only to special settings of mental healthcare. Quality in this context is a dynamic process and has a normative aspect. Essential for future revisions of this guidance will be the question, which processes really occur, in mental healthcare services and how effective these are.

Quality (general definitions, descriptions and examples)

The definition of "quality" in the context of a discussion of general health services or mental health service structures has not yet been universally agreed upon. Several alternatives are available [45]. The American Society for Quality defines quality as *"a subjective term for which each person or sector has their own definition"*. Further definitions are *"fitness for use"* and *"conformance to requirements"* [8]. According to Campbell et al. [25], quality can be defined in a generic or in a disaggregated way. Among the "generic" definitions, the Institute of Medicine (a non-profit, non-governmental U.S. organisation) has defined quality as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"*. The disaggregated approaches focus on the aspect of "quality" as a complex and multidimensional construct, which is defined according to several dimensions or components [25]. Campbell et al. [25] propose that access to and effectiveness of services are the only two domains of quality. Maxwell identified six separate but inter-related dimensions of the quality of healthcare, which offer a framework for establishing standards and which can be applied to any healthcare setting: access to service, relevance to need, effectiveness, equity, social acceptability, efficiency and economy. Concerning the quality of services, Maxwell points out that it is important to examine how the healthcare system performs as a whole rather than its fragmented parts [149]. This is particularly true considering that in our fragmented healthcare systems there is a multitude of services involved in the treatment and care of patients. Harteloh [65] differentiates between a descriptive and a prescriptive approach of the quality concept. While the descriptive approach exemplifies the meaning of quality as a property, the prescriptive approach defines the meaning of quality as a category of judgement. The author explains a rule for interpreting the abstract concept of quality: "the term 'quality' is applied as a ratio of possibilities realised on the one hand and a normative frame of reference on the other". The definition of ISO 8402 [71] is an example for a descriptive definition, where quality is described as an intrinsic property or condition: *"Product and service quality can be defined as the total composite product and service characteristics of marketing, engineering, manufacture, and maintenance through which the product and service in use will meet the expectations of the customers"*. The following definition from Lohr et al. [94] is also an example for a prescriptive definition: *"Quality of care is a multidimensional concept reflecting a judgement that the services rendered to a patient were those most likely to produce the best outcomes that could reasonably be accepted for the individual patient and those services were given with due attention to the patient-physician relationship"*. This is the basic definition, which we followed.

Generic aspects of quality (summary of generally accepted quality standards)

The eight quality management principles of the ISO (International Organisation for Standardisation) are: customer focus, leadership, involvement of people, process approach, system approach to management, continual improvement, factual approach to decision making, mutually beneficial supplier relationships.

The World Health Organisation Assessment Instrument for Mental Health Systems (WHO-AIMS) [139,143] was developed to assess key components of mental health systems for middle- and low-income countries. It still appears to provide a range of useful suggestions for the mental healthcare structures and models in Europe, as some European countries belong to the group of low- and middle-income countries, and since some general recommendations are independent of the income level of a society. This comprehensive instrument consists of six domains: policy and legislative framework, mental health services, mental health in primary care, human resources, public information and links with other sectors, and monitoring and research. These domains address the 10 components of the World Health Report 2001 [136]:

- Provide treatment in primary care;
- Make psychotropic drugs available;
- Give care in the community;
- Educate the public;
- Involve communities, families and consumers;
- Establish national policies, programmes and legislation;
- Develop human resources;
- Link with other sectors;
- Monitor community mental health;
- Support more research.

The WHO-AIMS primarily consists of input indicators, which are related to resources that are used to develop or modify services, and process indicators dealing with the assessment of service utilisation as well as aspects of service quality. As the WHO-AIMS provides essential information for mental health policy and service delivery, countries or regions will have a comprehensive picture of the main weaknesses of their mental health system, and this knowledge can initiate and facilitate improvements. Most items in WHO-AIMS describe aggregate information, but further development of this instrument may involve linking collected data with geographical information systems to map within-country differences [118]. On a regional or national level, the fulfilment of patient needs appears to offer a guide as to translation of findings from psychiatric epidemiology, general health needs and social factors into service facility needs estimates [124]. Discrepancies between staff and patients views may occur, and needs assessment are closely intertwined with questions of patient satisfaction [121]. A draft toolkit to monitor human rights in mental health and social care institutions has been developed by the Institutional Treatment, Human Rights and Care Assessment (ITHACA) project and the WHO Department of Mental Health and Substance Abuse [72,81]. This toolkit can be applied in different settings, like in psychiatric hospitals, psychiatric wards of general hospitals, rehabilitation centres, day centres, community services and high security psychiatry facilities. A schematic overview of the requested human rights is already available. Taken together, a wide range of measures has been developed, but they either focus on selected aspects or seem to be too globally oriented to serve as models for a European guidance.

Quality of structures, processes, and outcomes

Quality of healthcare in general has been classified by Donabedian [45] in the three categories: "structure", "process" and "outcome". This is the basic distinction which we have followed here. "Structure" constitutes the attributes of care settings like facilities, equipment, human resources and organisational structures. "Process" indicates the activities in giving and receiving care which includes the activities of healthcare providers. "Outcome" as the third category

denotes the effects of care. According to Donabedian, information about the relationships between structures, processes and outcomes should be ascertained before quality assessment can begin [45]. Campbell et al. [25] suggest that structure is not a component of care but the conduit through which treatment and care is received and delivered. Thus, outcome is not considered a component but rather a consequence of treatment and care. "Structures" may increase or decrease the likelihood of receiving high quality care because they can have a direct or indirect impact on processes and outcomes, e.g. if special equipment is not available. Corresponding to Donabedian's framework for quality of care, Hermann et al. [66] defined structure, process and outcome as the key domains of quality. Probably the first quantitative study, which applied Donabedian's model to quality systems came to the result that structure correlated strongly with process and outcome [85]. Organisational characteristics associated with better disease control were reported, e.g., from diabetes research [73]. However, there are no current procedures or definitions specifically addressing these issues in mental healthcare. Following Donabedian's model, Kilbourne et al. described a framework for measuring quality and promoting accountability across mental and general healthcare providers [78].

Quality assessment

Two types of organisational quality assessment can be distinguished: (a) mandatory and (b) optional data collection and evaluation programmes. While compulsory assessment is often carried out by governments or agencies, the voluntary quality assessment is usually carried out by professional organisations [87]. Donabedian's framework can be used to evaluate quality based on structure, process and outcome. Quality assurance procedures should result in quality maintenance and ultimately improvement. This may not always be the case as programs or projects may not comply with professional standards [76]. Targeted quality measures can be used for quality improvement within an institution (internal quality improvement) or across institutions (external quality improvement). As evidence in healthcare quality is frequently unavailable, guidelines and quality indicators based on consensus techniques may be needed to facilitate quality improvement. As measuring alone will not automatically lead to improvement, indicators have to be used within systems of quality improvement measures [26]. External quality improvement should be characterised by explicit, valid standards, by structured assessment procedures and complementary mechanisms for implementing improvement [87]. Usually, continuous quality activities aim at improving the structural and process components of care to ascertain positive effects on outcomes [64]. However, it should be noted that quality improvement cannot succeed if it is associated with disproportionately exaggerated documentation efforts or unacceptable for users for other reasons [81]. Thus, both utility and feasibility are essential in developing effective quality improvement measures for clinical practice.

Quality indicators

Indicators are described as explicitly defined and measurable items which act as building blocks in the assessment of healthcare. They may take the form of a statement about the structure, process or outcomes of care. An indicator can also be defined as *"a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality, and hence change in the quality, of care provided"* [91]. Indicators need to be based upon scientific evidence of acceptability, feasibility, reliability, sensitivity to change and – most important – validity. Obeying this rule, the effectiveness of quality indicators in quality improvement strategies can be maximised [26,51]. Quality indicators for mental health service structures and processes especially related to treatment processes for specific disorders are currently being developed and cover a range of processes and structures [67–70,89,91–93,120,123,147,148].

For the present guidance, we had to take into account a complex interrelationship between mental health service structures, outcomes and quality indicators (Fig. 1).

As can be seen from the figure, mental health services are characterized by structural and process elements for which any number *n* of quality indicators may be defined. These generic quality indicators are useful to assess the quality of services or provide benchmarking indicators for comparing individual services in different places. Outcome is assessed by outcome quality indicators. They are different from quality indicators for mental health service structures, but the quality of mental healthcare service structures may be assessed using outcome indicators. Therefore, some outcome indicators may overlap with quality indicators of mental health service structures.

Mental health services in general should provide both structural and process quality. For example, minimum staffing requirements may be necessary for a certain service structure (QI_S), or certain process rules must be adhered to for a certain service under certain circumstances (e.g., rules for the time until a newly admitted patient is seen by a psychiatrist; QI_P). These quality indicators allow quality assessments of the service structure and its processes per se, they are determined by empirical studies and may then become normative features, or they may be defined via patient outcomes. They may also serve for inter-service benchmarking. Outcome assessments are performed, for example using clinical outcomes like disease remission rates (QI_O), and these are values and not service structures or processes. However, patient outcomes are influenced by service structures and processes and therefore service-specific quality indicators may also be defined as outcomes (QI_P or QI_S may then be identical to QI_O). Other outcome quality indicators may comprise patient satisfaction, retention in services, frequency of readmissions, social functioning, activities of daily living and many others.

Quality management

Some techniques and concepts of Total Quality Management incorporated into the management of mental health organisations arose from the manufacturing and industrial sectors mainly to reduce costs [139]. The International Organisation for Standardisation (ISO) and the EFQM model (European Foundation for Quality Management) are examples of industrial models of quality improvement that have been applied to healthcare. The EFQM model promotes quality improvement through self-assessment while ISO focuses on the implementation of international norms [90].

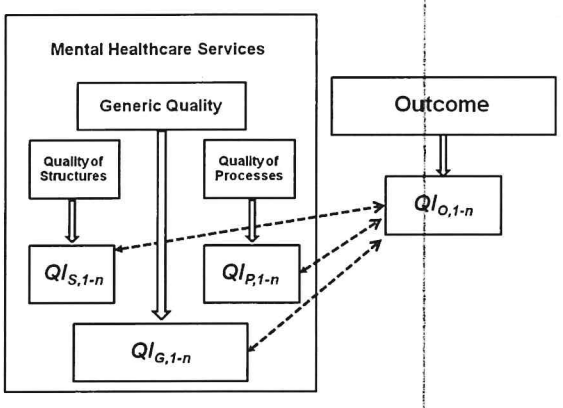

Fig. 1. Complex interrelationship between mental healthcare service structures, processes, outcomes and quality indicators. QI = quality indicator. The suffix "G" denotes a generic indicator, the suffix "S" denotes a structure indicator, the suffix "P" denotes a process indicator, the suffix "O" denotes an outcome indicator. Any number *n* of quality indicators may be defined for a given mental healthcare service.

Box 2. Mental Health Services

For the purpose of this guidance, we define mental health services as the "Specialist provision of mental health and social care provision integrated across organisational boundaries." (Source: A National Service Framework for Mental Health; National Health System; http://www.acutecareprogramme.org.uk/silo/files/national-service-framework-for-mental-health.pdf). A psychiatric service is any service providing diagnosis, treatment and other types of healthcare to people with mental disorders and in which a psychiatrist has the final medical responsibility (this definition was created by the authors of this guidance, since no standard definition for the term "psychiatric service" could be found). European mental healthcare services are characterized by a mixture of in- and out-patient services with curative or rehabilitative approaches. In addition, there are services which integrate in- and out-patient services. We have studied the following service types. This selection was made by the authors of this guidance with the aim to cover all mental health services:

1. Hospitals/In-patient services
2. Out-patient services
2.1. Home-based Treatment (used here as a term for a specialised form of community-based care)
2.2. Community Mental Health Teams (used here as a term for a specialised form of community-based care)
2.3. Intensive Case Management (used here as a term encompassing both assertive community treatment and case management)
2.3.1. Assertive Community Treatment
2.3.2. Case Management
2.4. Day Hospitals
3. Rehabilitation Units
4. Integrated Care Models

We used the term "out-patient services" here as a supraordinate term for several types of out-patient services, which are further specified and described in separate chapters. Note that Rehabilitation Units may be provided in in- and out-patient settings, but are dealt with here separately because of the special nature of rehabilitation services. Also, integrated care models would be expected to cross the border between in- and out-patient services and provide access and treatment in both areas. In some countries like Germany, out-patient mental health services are mainly provided by psychiatrists in private practices. However, there are currently no systematic studies on quality indicators or structural or process recommendations yet available for this special type of mental health services.

Hospitals/In-patient Services

In-patient services provide treatment and stabilisation when the required services cannot be delivered in community settings [127–129]. There are certain groups of patients, who usually require high-intensity immediate support in acute in-patient hospital units (sometimes also on a compulsory basis):

- patients who need urgent medical assessment;
- patients who suffer from severe and co-morbid medical and psychiatric conditions which cannot be controlled on an out-patient basis or in other kinds of settings;
- severe psychiatric relapses and behavioural disturbances;
- strong violence, suicidality;
- acute neuropsychiatric conditions;
- old age and severe concomitant physical disorders.

Mental health services in general hospitals include psychiatric in-patient wards, psychiatric beds in general wards and emergency departments, day hospitals and out-patients clinics. They serve a range of diagnostic and demographic groups and some offer specialist services for specific disorders or patient groups [137–139]. The availability of psychiatric beds in the European countries varies greatly, but there are considerable methodological problems in comparing "psychiatric bed" numbers between countries due to incomplete reporting or varying definitions of service classes between countries [142]. Thus, the large variation of psychiatric hospital beds among European countries may be due to a number of factors including reporting standards and organisational issues.

Out-patient services

Out-patient services can be provided in different settings, such as primary care health centres, general hospitals and community mental health centres, where diagnostic assessment and treatment is offered [126]. Most of them are staffed exclusively with medical doctors (around 80%), 9% include psychologists, 17% provide care by nurses according to service mapping data in England. Some of these clinics function as specialist services, e.g. for people with eating disorders, or in need for various kinds of rehabilitation [60].

Day hospitals

While the function of day hospitals formerly was to mainly provide a place for follow-up-treatment after an acute in-patient episode, they increasingly take a role in the acute treatment of mentally ill [77]. They may even be an alternative to in-patient treatment for many acute care patients. Day hospitals are facilities which offer intermediate interventions between full-time hospitalisations and out-patient care.

Rehabilitation units

Rehabilitation settings for people with mental illnesses generally include rehabilitation units in psychiatric hospitals or specialised psychiatric rehabilitation in-patient units, vocational services and day activity/recreational services [29,113,114]. Evidence-based practice is increasingly implemented and the evidence is strongest for assertive community treatment, supported employment and family psychoeducation [14]. However, implementation of these interventions is often impeded by motivational and organisational barriers even if the required structures would be available [98]. In Europe, generally accepted standards for psychiatric rehabilitation units are currently not available. In Germany, the national working group on rehabilitation ("Bundesarbeitsgemeinschaft für Rehabilitation") has issued recommendations for basic structural and organisational requirements for psychiatric rehabilitation. These include, among others, that rehabilitation units should be available close to the clients' home, that services should be well coordinated between rehabilitation and general practitioners' services, that members of the social environment of those in need of psychiatric rehabilitation should be involved in the rehabilitation process, and that an interdisciplinary team of mental health professionals should be available [17]. There is a clear common understanding that rehabilitation should be offered primarily in the natural environment of the affected persons.

Community-based care

Community-based mental healthcare services comprise out-patient clinics, day hospitals, home treatment services, and community mental health teams in community mental health centres [115]. According to Thornicroft and Tansella [129], a community-based mental health service provides a full range of mental healthcare to a defined population and is dedicated to treating and helping people with mental disorders, in proportion to their suffering or distress, in collaboration with other local agencies. Thornicroft et al. [130] also mention that there are wide inconsistencies between and within countries in how community – oriented care is defined, interpreted and provided. The objective is a "balanced care model", which provides most services in community settings while hospital stays should be reduced as far as possible. Services need to be adapted to the specific needs of low-resource-, medium-resource- and high-resource-countries, low resource areas may

need to focus on the provision of mental healthcare through primary care, while areas with medium resources should provide more differentiated services. High-resource areas should provide all specialised services (e.g. in-patient care, community care, residential and rehabilitation care, alternative occupation) [126,128,129]. Types of diagnoses treated in community-based services largely depend on local, regional and national availability of the respective services, traditions and the availability of alternative types of services. Community-based treatment services usually are provided by an interdisciplinary team of mental health professionals. Treatment focuses on improving quality of life and on reducing the need for in-patient care.

Home treatment

Home treatment or crisis resolution teams offer mobile services and play an important role for acute and emergency treatment. Their services try to avoid in-patient care from the outset [9,20,21,60,132].

Community mental health teams

Community mental health teams (CMHTs) comprise nurses, one or more psychiatrists, social workers, psychologists, occupational therapists and possibly other professionals such as counsellors. They provide short- and long-term care. Usually, patients meet the mental health professionals at the team base [60].

Intensive Case Management

This term now incorporates both assertive community treatment and case management [43,115].

Assertive community treatment

Assertive Treatment teams (ACT) are also called "Assertive Outreach Teams" (e.g., in the UK) and are widespread by now. Assertive community treatment teams comprise psychiatrists, nurses, social workers and occupational therapists and are intended to provide long-term care for rather "difficult" patients, e.g., patients who do not accept treatment. The functions of ACTs are medication management, monitoring the state of health and to offer help in everyday life [9,60]. Assertive community treatment can be viewed as a specialised form of case management, not a categorically different approach [18]. It is usually defined by treatment manuals and fidelity scales, and it includes special features such as daily team meetings, case sharing, 24 hour availability and doctors as full team members [99].

Case management

Case management includes the coordination of various services and aims for continuity of care and service. Case management combines the activities of linking (referring patients to all required services), monitoring and case-specific advocacy. A case manager serves a certain number of patients and has to cooperate with several mental health services [43,115].

Integrated care models

Kodner and Spreeuwenberg [83] provided a comprehensive definition of integrated care based on a terminological clarification of the different meanings of the term "integration": "Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called "integrated care". Integrated care models thus constitute an organisational framework in which important therapeutic modules are administered according to individual requirements especially for people with severe mental illnesses like schizophrenia. These models facilitate synergies between out-patient and in-patient care and also should ascertain continuity of care [134]. In Germany, some of these models have been tested but only few – mainly health economic – evaluations are available [10]. As a special type of integrated care, the so-called regional budget in Germany involves the authorisation of a single provider of mental health services to finance a model of multi-sector mental healthcare services. This has been shown to have complex effects on total costs, modes of service provision, and some beneficial effects on patient outcome parameters [84,112].

Integrated care is used here in a narrow sense describing specialised mental health services following a set of standardized interventions and services. For example, the integrated care pathways (ICPs) for mental health standards have four main elements:

- process standards describe the key tasks which affect how well ICPs are developed in an area;
- generic care standards describe the interactions and interventions that should be generally offered;
- condition-specific care standards describe the interactions and interventions that must be offered to people with a specific condition;
- service improvement standards measure how ICPs are implemented and how variations from planned care are recorded [108,109].

the database literature searches sequentially and updated them if appropriate because of the time lag between the first search and the preparation of the final version of the manuscript. The first of our literature searches was on the quality of mental hospitals and details of the methods are given in Fig. 2.

Fifteen documents retrieved by this search are mentioned in the text [1,16,24,33,42,46,47,55,62–64,68,79,86,128]. This search strategy was supplemented in a second search on controlled trials and systematic reviews on a variety of mental health service structures. The exact search terms and methods are shown in Fig. 3.

This resulted in the additional identification of three controlled studies [7,32,88] and four review articles [28,50,80,131], which were used in this text.

We performed a further literature search in Medline (from 2005 on) on August 9, 2011, in order to better cover out-patient services and the details are given in Fig. 4.

One study showing reduced hospitalisation rates after out-patient waiting time reduction was used for the guidance [145], and another article dealing with in-patient mental health, which had already been identified previously [146]. We also screened the following papers of international and German journals, which published articles on the quality of mental healthcare in 2010, because this was the year in which most of the information retrieval work for this guidance was performed:

- *International Journal for Quality in Health Care*;
- *Journal for Health Care Quality*;
- *Quality Management in Health Care*;
- *Quality Assurance in Health Care*;
- *Gesundheitsökonomie und Qualitätsmanagement*;
- *Deutsches Ärzteblatt*;
- *Psychiatrische Praxis*;
- *Nervenarzt*;
- *Die Psychiatrie*.

Websites of various international and national institutes and organisations have also been screened once in early 2010 by K.S.:

- Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen;
- Institut für angewandte Qualitätsförderung u. Forschung im Gesundheitswesen;

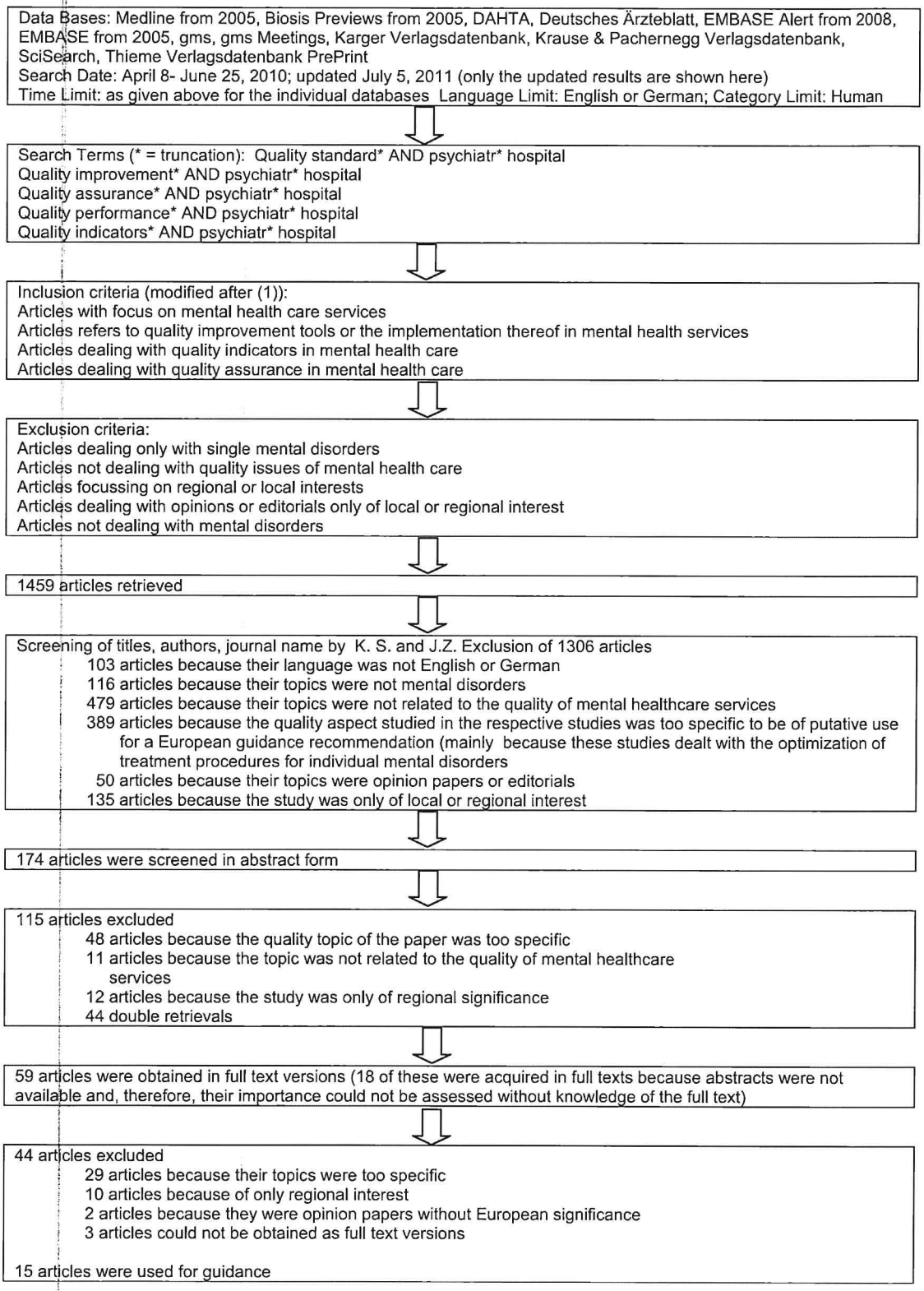

Fig. 2. Flow scheme of the initial literature search and the results pertaining to quality assessments in mental healthcare (see Figs. 3–4 for further literature searches).

- Dt. Krankenhausgesellschaft;
- Agency for Health Care Research and Quality;
- Maryland Hospital Association's Quality Indicator Project;
- WHO;
- Swedish Council on Health Technology Assessment;
- National Institute of Clinical Excellence (NICE-UK).

Further articles were identified by obtaining "related documents", which is a feature of the Medline database providing a list of publications which deal with similar publications compared to

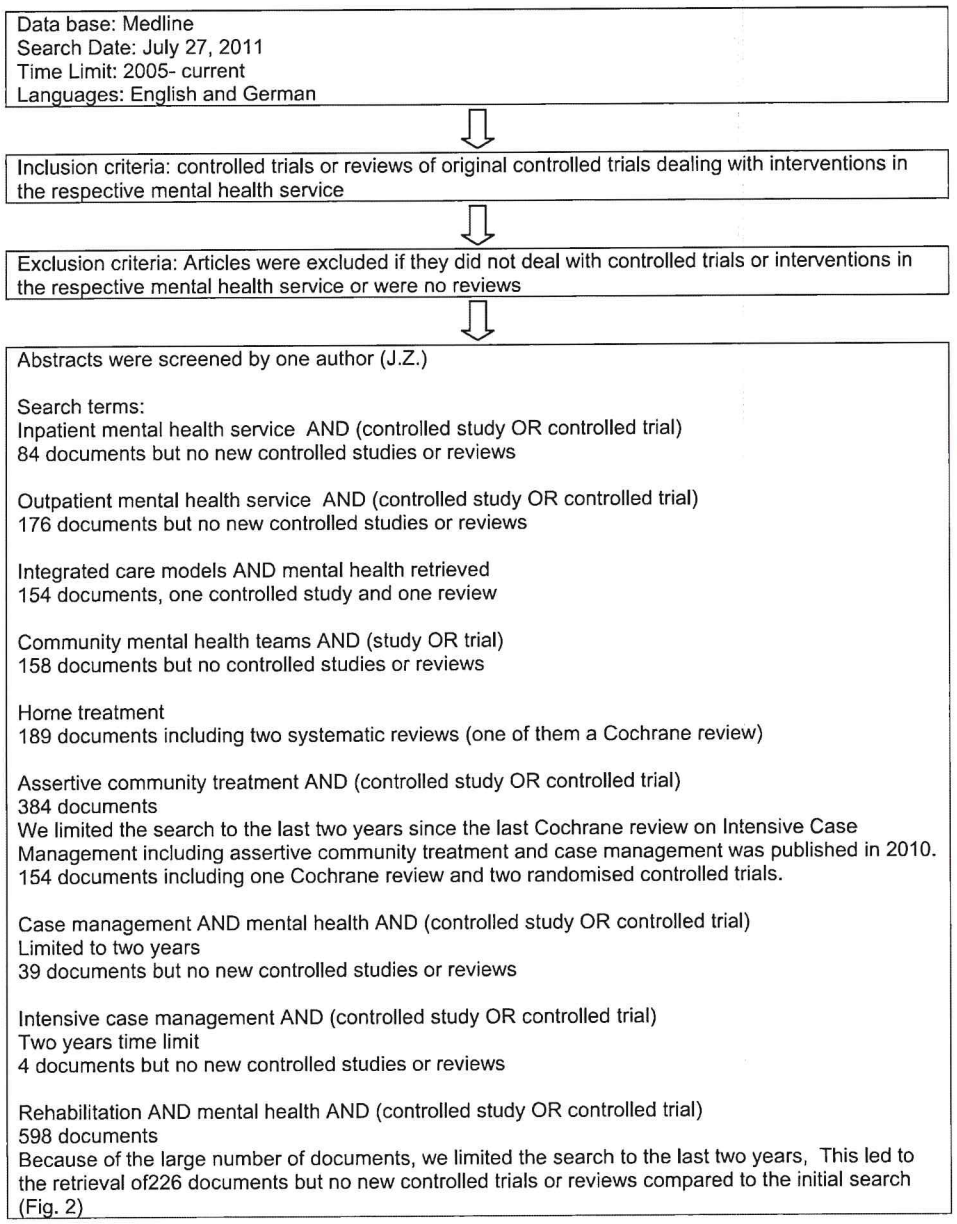

Fig. 3. Flow scheme of literature search specified for controlled single studies and review articles on specific types of mental healthcare.

those identified in a Medline search. These were screened by one co-author (J.Z.) whereby due to the large number of "related documents" only the first 100 were considered if the number of related documents for a retrieved document was larger than 100. Also, articles were identified because they were known personally to the authors or because the authors became aware of them when reading the documents which we had obtained. The total number of articles obtained via colleagues, related documents information, Website visits, reading articles and the reviews of the beforementioned journal homepages was $n = 128$, but we did not keep track of the dates or retrieval steps of these articles.

2.4. Process of developing recommendations

The recommendations were subjected to peer review by the co-authors, the Steering Committee of the European Psychiatric Association European Guidance and the Executive Committee of the EPA. We structured the guidance recommendations into structure and process as well as general and specific recommendations (Table 1). Whereas general (or "generic") recommendation and quality indicators (QIs) apply to all types of mental health services, service-specific QIs are only applicable to a certain type of mental health services, but not to other types. Outcome was not used here as a separate quality category since many studies assessed the results of their investigations on structure or process quality with the help of outcome measures. However, the range of applied psychiatric outcome measures is vast and encompasses patient-based outcomes (like the subjective quality of life in single patients, individual or group-wise clinical assessments of global or disease-specific psychiatric symptom scales and function scales including assessments of employment, independent living or death rates), administrative outcomes (like contact rates in various settings, hospital readmission rates, therapy rates like medication prescription rates, costs) or combinations thereof [59]. It needs to be defined what would be clinically meaningful outcome measures applicable to all European countries, all mental health service

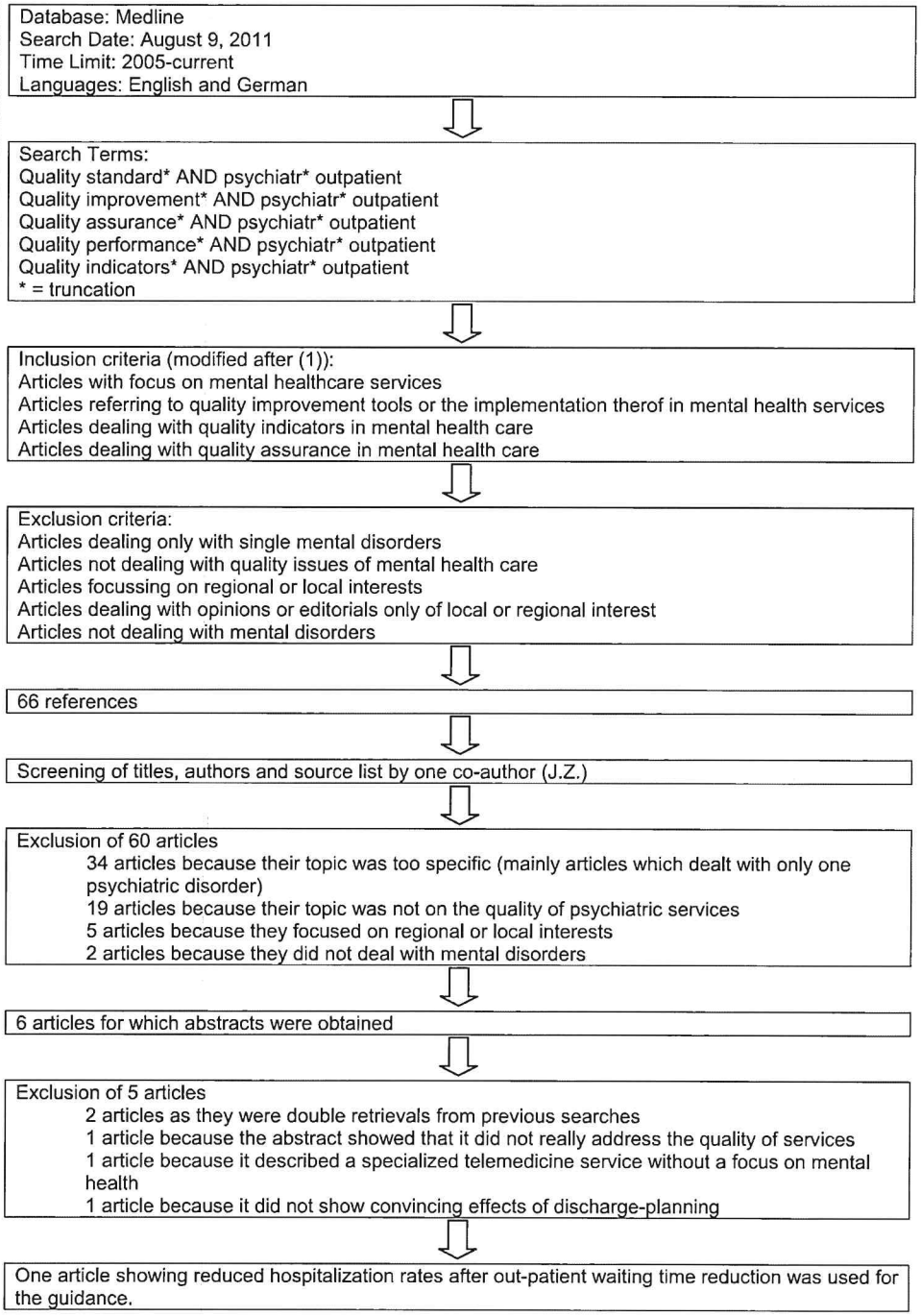

Fig. 4. Flow scheme of literature search specified on out-patient mental healthcare quality assessment studies.

settings, and all mental disorders. This will be the subject of a separate EPA guidance recommendation. Further details about the concept of quality used here are given in Info Box 1.

2.5. Grading of evidence and recommendations

Modified after a systematic review by Weightman et al. [133] for the grading of evidence and recommendations for public health interventions, the evidence retrieved in the literature search was graded following a three-part evidence rating system: +: expert opinion; ++: unsystematic reviews; +++: Cochrane Review or other systematic reviews. A systematic review is a review which predefines search terms and databases, gives details about inclusion and exclusion criteria, and provides details about the number of retrieved, included, and excluded documents, plus a commented list of documents used for the purpose of the systematic review. All other types of reviews are defined here as "unsystematic".

In some cases, single trials were used if no systematic reviews were available and graded instead of reviews, and in these cases, the evidence was graded as follows: +: single uncontrolled study; ++: single controlled, unrandomized study; +++: single controlled, randomized study. The recommendations were graded following a three-part recommendation rating system: *: recommendation

based mainly on expert opinion; **: recommendation based on expert opinion and/or unsystematic reviews and/or single uncontrolled or controlled, but unrandomized studies; ***: recommendation based on Cochrane reviews or other systematic reviews or single controlled, randomized studies.

2.6. Development of quality indicators

To develop quality indicators is a normative process, deciding on the range of values of a consented operational ratio with explicitly defined nominators and denominators based on empirical data. They have been structured as explained in the previous chapters. Quality indicators were developed by the authors of this guidance based on the developed recommendations. Where possible, we used quality indicators provided by the sources of the recommendations. In most cases, quality indicators here are formulated as ratios of nominators and denominators. Usually, the number of services which provide a certain structural or procedural feature is divided by the total number of services. This may then be multiplied by 100, which gives the percentage of services providing a certain feature. Definitions of these quality indicators are given in Table 1.

3. Results

Table 1 summarizes the consented general and setting-specific recommendations for the assessment, assurance and optimisation of structure and process quality of mental health services in Europe, including gradings for evidence and recommendations, additional comments, and source informations.

This table should not be regarded as a "cookbook" for mental health services, but rather as a guide to important aspects when evaluating, developing or managing such services with respect to quality. Note that we have omitted important but rather self-explanatory components like access to fresh air or adequate staffing from the list mainly due to the fact that such elementary quality indicators can be found in generally accessible standards like those published by the Royal College of Psychiatrists (see references in Table 1). Based on the expert consensus and the retrieved evidence, the following 30 recommendations can be given on the following subjects. However, general structure recommendations on the microlevel and specific structure recommendations on both the macro- and mesolevel, as well as general process recommendations on the macrolevel and specific process recommendations on both the macro- and mesolevel cannot be given mainly because of a lack of studies.

3.1. Structure recommendations

3.1.1. General structure recommendations

3.1.1.1. Macrolevel recommendations.

3.1.1.1.1. Recommendation 1: Mental health education. Provide coordinating bodies (e.g., committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders.

This recommendation is based on the WHO-AIMS Version 2.2. [143] and ensures that mental health policies are coordinated, which appears to be an important aspect to the developers of this guidance given the beformentioned mix of service structures found in European countries. The second part of the recommendation ensures that public education on mental disorders becomes a topic of awareness campaigns, which is important to ascertain that the public knows about the typical signs, symptoms and treatment opportunities for mental disorders. This recommendation is expert opinion-based since we could not identify studies showing that such coordinating bodies or awareness campaigns lead to improved detection or better treatment of people with mental disorders.

3.1.1.1.2. Recommendation 2: Mental health reporting and monitoring. Install mental health information systems to monitor the epidemiology of mental disorders and data on the number of mental healthcare facilities, their regional distribution, frequency and type of use, staffing, and mental health research. The items mentioned in this recommendation are derived from the respective chapter (domain 6) in the WHO-AIMS Version 2.2. [143]. They are important for providing sufficient and even access to mental health services, and in order to ascertain progress in mental health research. These are the core features of mental healthcare systems–according to the opinion of the authors of this guidance – and need to be monitored and ascertained. This is an expert opinion because studies withholding such key tenets of mental healthcare in a systematized fashion would be unethical.

3.1.1.2. Mesolevel recommendations.

3.1.1.2.1. Recommendation 3: Structural requirements to ascertain patients' dignity and basic needs. Implement the ITHACA Toolkit items to ascertain that the structural requirements of in- and outpatient mental healthcare facilities are met for the fulfilment of patients' basic needs, and to ascertain that patients' dignity and human rights are observed at all times. This general structure recommendation uses the ITHACA Tookit [72], which provides a compilation of 30 sections for monitoring human rights in mental health and socal care institutions, and which is partly overlapping with corresponding recommendations in the Royal College of Psychiatrist assessment of psychiatric wards [30], and the Finnish Quality Recommendations for Mental Health Services [104]. Ascertaining human rights and the basic needs of people with mental disorders is of prime importance on the service structure level and was therefore chosen as the first recommendation on the mesolevel. Similar to recommendation 2, it would be unethical to withhold such basic rights in putative controlled studies on this subject matter, therefore the recommendation can only be on the expert level.

3.1.1.2.2. Recommendation 4: Multiprofessionality of services. Assemble multiprofessional teams with competences in social occupational-, work- and housing-related service provision. Multiprofessional teams caring for people with mental disorders are efficient, based on the evidence showing that community mental health teams, assertive community treatment teams and other types of intensive case management are efficient [reviewed by 43, 53, 97]. However, no study has formally shown that the multiprofessionality is superior to uniprofessionality, simply because such studies would ethically unfeasible and impractical. Therefore, this recommendation is based on both expert opinion and Cochrane review of international systematic studies on multiprofessional services. Following conclusions in [52], such multiprofessional teams should include a psychiatrist within an interdisciplinary team comprised of medical and social professions.

3.1.1.2.3. Recommendation 5: Access to good primary mental healthcare and specialised psychiatric care. Provide access to good primary care for mental health problems by developing primary care services with the capacity to detect and treat mental health problems, and create centres of competence and promote networks in each region; ensure access to specialised psychiatric services for those in need. Primary care here is defined as a form of healthcare which is the primary contact point of help-seeking persons. "Access" here is defined as a timely appointment for every person with a mental disorder who is in need of specialised psychiatric services. The rationale for this recommendation is the individualisation of treatment provision in that both basic and

Table 1
EPA guidance on quality of mental health services – evidence base and recommendations.

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
General structure recommendations					
Macrolevel recommendations					
Recommendation 1: Mental health education	Provide coordinating bodies (e.g., committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders*	WHO Assessment Instrument for Mental Health Systems*	Number of coordination bodies (e.g., committees, boards, offices that coordinate and oversee public education and awareness campaigns on mental health and mental disorders) per 100,000 population	Summarised recommendation derived from Items 5.1.1 in [143]: "Existence of coordinating bodies (e.g. committees, boards, offices) that coordinate and oversee public education and awareness campaigns on mental health and mental disorders"	[143] (WHO-AIMS Version 2.2.)[c*]
Recommendation 2: Mental health reporting and monitoring	Install mental health information systems to monitor the epidemiology of mental disorders and data on the number of mental healthcare facilities, their regional distribution, frequency and type of use, staffing, and mental health research*	WHO Assessment Instrument for Mental Health Systems*	Presence of a mental health information system providing annually updated information of the number of mental healthcare facilities, their regional distribution, their staffing and use (numbers of patients per diagnosis per year and per service)	Summarised recommendation derived from Domain 6 in [143]: items include that there is a formally defined list of individual data items that ought to be collected, that there is a proportion of mental hospitals, community-based psychiatric in-patient units, and mental health out-patient facilities routinely collecting and compiling data by type of information, that there is a proportion of mental health facilities from which the government health department received data in the last year, that there is a report covering mental health data by the government health department in the last year, that there is monitoring of the mental health professionals working in mental health services who have been involved as researchers in the last five years	[143] (WHO-AIMS Version 2.2.)[c*]
Mesolevel Recommendations					
Recommendation 3: Structural requirements to ascertain patients' dignity and basic needs	Follow the requirements of the ITHACA Toolkit items to ascertain that the structural requirements of in- and out-patient mental healthcare facilities are met for the fulfilment of patients' basic needs, and to ascertain that patients' dignity and human rights are observed at all times[1]	Expert opinion*	Number of mental healthcare facilities following the ITHACA toolkit recommendations divided by the number of mental healthcare facilities not following the ITHACA toolkit recommendations	The Ithaca toolkit provides a compilation of 30 sections for monitoring human rights in mental health and social care institutions with many recommendations similar to the recommendations by the Royal College of Psychiatrists for acute psychiatric wards [30]. This recommendation corresponds with recommendation 1 of the Finnish Quality Recommendations for Mental Health Services [72]	[72] (ITHACA Toolkit)[d], [104]
Recommendation 4: Multiprofessionality of services	Assemble multiprofessional teams with competences in social occupational-, work- and housing-related service provision***	Expert opinion based on a metareview and Cochrane reviews of international studies***	Number of multiprofessional teams per 100,000 people with mental disorders	Recommendation in agreement with similar recommendation in the conclusion chapter of [52] and evidence for the efficiency of community mental health teams, assertive community treatment and other types of intensive case management usually involving multiprofessional teams [43,97]	[43,52,97]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 5: Access to good primary mental healthcare and specialised psychiatric care	Provide access to good primary care for mental health problems by developing primary care services with the capacity to detect and treat mental health problems, and create centres of competence and promote networks in each region; ensure access to specialised psychiatric services for those in need*	Expert opinion*	Number of primary mental health services. Korrigiert per 100,000 people with mental disorders Number of competence centres for psychiatry per 100,000 people with mental disorders Competence centers for the purpose of this guidance are those centers which health professionals, service users, carers and the media can contact for advice on the management of mental disorders	Structural recommendation in recommendation 6 on the need for good primary care for mental health problems ("Ensure that all people have good access to mental health services in primary care setting", "Create centers of competence and promote networks in each region which health professionals, service users, carer and the media can contact for advice.", "Design and implement treatment and referral protocols in primary care establishing good practice and clearly defining the respective responsibilities in networks of primary care and specialist mental health services") [140] This recommendation corresponds with recommendations 3 and 7 of the Finnish Quality Recommendations for Mental Health Services [104]	[140] (Mental Health Action Plan for Europe, WHO Europe, 2005)", [104]
Recommendation 6: Availability of technological equipment for assessment and treatment	Provide all state of the art evidence-based technological diagnostic and therapeutic equipment and services to help-seekers within 72 hours for non-acute cases and immediate access for acute cases*	Expert opinion*	Number of in- and out-patient services which provide access to major evidence-based diagnostic and therapeutic technologies within 72 hours for non-acute cases and immediate access for acute cases divided by the number of in- and out-patient services without such a provision ECG Chest X-ray Laboratory tests EEG MRI CT Electroconvulsive therapy	Developed by authors	Expert opinion
Recommendation 7: Psychiatric workforce	Create a sufficient and competent workforce ensuring an equitable distribution and develop specialist training streams*	Expert opinion*	Number of psychiatrists in out-patient psychiatric services per 100,000 people with mental disorders Number of psychiatrists in hospitals per 100,000 people with mental disorders	Structural recommendation in recommendation 9 ("Create a sufficient and competent workforce") [140] This recommendation corresponds with recommendations 9 and 10 of the Finnish Quality Recommendations for Mental Health Services [104]	[140] (Mental Health Action Plan for Europe, WHO Europe, 2005)", [104]
Recommendation 8: Catchment areas	Ensure that catchment areas/ service areas are implemented as a way to organise psychiatric services to communities*	WHO Assessment Instrument for Mental Health Systems*	Number of people living in areas in which catchment areas are defined divided by the number of people living in areas in which no catchment areas were defined	Item 2.1.2 in [143]: "Catchment areas/ service areas exist as a way to organize mental health services to communities"	[143] (WHO-AIMS Version 2.2)"*

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 9: Day hospitals for people with acute mental disorders	Develop day hospital services for people with acute mental disorders[***]	Cochrane review based on nine randomised controlled studies[***]	Number of "places" in day hospital services for people with acute mental disorders per 100,000 people with acute mental disorders	Caring for people in acute day hospitals can achieve substantial reductions in the number of people needing in-patient care, whilst improving patient outcome. This review only considered studies with acute day hospitals and patient characteristics were not further described. However, the definition of a "day hospital" in the sense of this Cochrane review was "diagnostic and treatment services for acutely ill patients who would otherwise be treated on traditional psychiatric in-patient units" [100]. Therefore, the conclusions from the Cochrane review were formulated by the authors to pertain to "acute mental disorders" for the purposes of this guidance	[100]
Recommendation 10: Psychiatric care for members of minority groups	Provide adequate psychiatric care facilities for linguistic, ethnic and religious minority groups[*]	WHO Assessment Instrument for Mental Health Systems[+]	Number of linguistic, ethnic and religious minority groups for which specialised mental healthcare services are available divided by the number of linguistic, ethnic and religious minority groups for which specialised mental healthcare services are not available	Summarised recommendation derived from Items 2.11.3-5 [143]: 2.11.3: "Percentage of mental health out-patient facilities that employ a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent" 2.11.4: "Proportionate use of mental health services by ethnic and religious minority groups in comparison to their relative population size" 2.11.5: "Proportionate number of ethnic and religious minority groups admissions to mental hospitals in comparison to their relative population size"	[143] (WHO-AIMS Version 2.2)[c]
Specific Structure Recommendations					
Microlevel recommendations					
Recommendation 11: Essential in-patient services structural requirements	Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities")[†]	Expert opinion[+]	Number of psychiatric hospitals/ in-patient psychiatric services fulfilling the essential structural requirements outlined as Type 1 recommendations in Part 2 "Staffing" of Section 1 and Section 4 ("Environment and Facilities") as recommender by the Royal College of Psychiatrists AIMS guidance divided by the number of services not fulfilling these requirements Each psychiatric ward is counted as a service unit	General recommendations on staffing and structures of psychiatric wards	[30]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 12: Essential out-patient services structural requirements	Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance for in-patient services (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities")*	Expert opinion*	Number of out-patient services fulfilling the essential structural requirements outlined as Type 1 recommendations in Part 2 "Staffing" of Section 1 and Section 4 ("Environment and Facilities") as recommender by the Royal College of Psychiatrists AIMS guidance divided by the number of services not fulfilling these requirements	General recommendations on staffing and structures of psychiatric wards which may in analogy be used as best practice recommendations for out-patient services	[30]
Recommendation 13: Essential rehabilitation services structural requirements	Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2 "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities")*	Expert opinion*	Number of rehabilitation wards fulfilling the structural requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance (Part 2 "staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities") divided by the total number of rehabilitation units	General recommendations on staffing and structures of psychiatric wards, in which Type 1 recommendations are the essential ones	[31]
Recommendation 14: Community mental health teams for people with severe mental illnesses	Develop a system of community mental health teams for people with severe mental illnesses and disordered personality**	Cochrane review based on three randomised controlled studies***	Number of community mental health teams for people with severe mental illnesses or personality disorders per 100,000 people with severe mental illness or personality disorders	Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. "Personality disorder" was not closer defined in this study, but the term "personality disorder" was used as a search term for the identification of studies of putative relevance for this Cochrane review	[97]
Recommendation 15: Intensive Case Management	Implement Intensive Case Management services for severely mentally ill persons with high hospital use***	Cochrane review of 38 trials***	Number of severely ill persons in Intensive Case Management divided by the total number of severely ill persons	This subgroup of patients benefited from intensive case management (reduced hospitalisations, increased retention in care). "Severe mental illness" was defined using the National Institute of Mental Health criteria (Note by the Authors: this involves a diagnosis of non-organic psychosis or personality disorder, duration characterized as involving "prolonged illness" and "long term treatment" and operationalised as a two-year or longer history of mental illness or treatment, and disability, which includes dangerous or disturbing social behaviour, moderate impairment in work and non-work activities and mild impairment in basic needs), and, in the absence of these criteria, an illness such as schizophrenia, schizophrenia-like disorders, bipolar disorder, depression with psychotic features or/and personality disorder [43]	[43]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 16: Integrated Care Models	Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers**	Expert opinion based on a metareview of international studies**	Number of integrated models of cooperative community care providing evidence-based services with joint budgetary responsibility of participating service providers divided by the sum of the numbers of psychiatric hospitals, psychiatric departments in general hospitals, out-patient mental healthcare services and private psychiatric practices	Recommendation derived from similar recommendations in the conclusion chapter of Ref. [52]	[52]
Process recommendations					
General process recommendations					
Mesolevel recommendations					
Recommendation 17: Evidence-based medicine	Follow the rules of evidence-based medicine in diagnostic and therapeutic decisions**	Systematic reviews and single studies**	Numbers of mental health services (in- and out-patient) with implemented standard operating procedures ascertaining obedience to the rules of evidence-based medicine divided by the number of mental health services (in- and out-patient) without such implemented standard operating procedures	Reviews and single studies show that following evidence-based medicine guidelines leads to improved outcome	[147]
Microlevel recommendations					
Recommendation 18: Safety issues	Implement operational policies in psychiatric facilities to ascertain patient and staff safety, e.g., with efficient alarm systems, and to manage violent patient behaviour*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of the mental health services (in- and out-patient) with standard operational policies to ascertain patient and staff safety divided by the number of those without such standard operational policies Operational policies defined here for the purpose of this guidance as predefined standard procedures which are used to deal with specific organisational tasks	Recommendations in Numbers 18.1–18.5 (safety), 19.1–19.9. (management of violence), 20.1–20.7 (falls), 21.1–21.3 (pressure ulcer care), 22.1–22.5 (infection control), 23.1–23.2 (management of alcohol and illicit drugs), 24.1–24.7 (safety) and 25.1 (alarm systems)	[30] (Royal College of Psychiatrists)[f]
Recommendation 19: Informed consent	Ascertain that the choice of treatment is made jointly by the patient and the responsible clinician based on an informed consent*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of patients in all mental health services treated with informed consent divided by the number of patients in all mental health services treated without informed consent	Recommendation 37.1 generalized here to apply to all patients in all types of mental health services and not only related to medication decisions: "The choice of medication is made following consultation with the patient and/or carer and the responsible clinician based on an informed discussion of: the relative benefits of the medication; the side-effects; alternatives; the route of administration (which may include consideration of the need for covert medicines administration if medication refusal is an issue)"	[30] (Royal College of Psychiatrists)[f]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 20: Monitoring of physical illness and access to general and specialised medical services	Monitor physical illness and provide timely access to general and specialised medical services when necessary**	WPA recommendation on physical illness in patients with mental disorders and EPA position statement on cardiovascular disease and diabetes in people with severe mental illness (unsystematic reviews)**	Number of patients with mental illness and with physical illness monitoring divided by the total number of patients with mental illness	In correspondence with recommendation 4 at the system level (e.g., population-wide recommendations as contrasted to individual level actions recommended) [39], to improve access to and care of physical health of people with severe mental illness ("Improve access and care of physical health of the SMI population") SMI = severe mental illness	[36,38,39]
Specific process recommendations Microlevel recommendations					
Recommendation 21: Hospitals/ In-patient Services: basic requirements	Implement the essential process requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS (Section 2 "Timely and Purposeful Admission" and Section 3 "Safety")*	Expert opinion*	Number of patients admitted to mental hospitals and other in-patient services for which Type 1 recommendations of Section 2 ("Timely and Purposeful Admission") and Section 3 ("Safety") are fulfilled divided by the total number of admitted patients	These Type 1 recommendations are essential elements of the general recommendations on staffing and structures of psychiatric wards, which are here focused on timely and purposeful admission and safety aspects as the key elements for providing basic requirements	[30] (Royal College of Psychiatrists)[f]
Recommendation 22: Hospitals/ In-patient Services: admission procedures	Ensure that on the day of their admission to a psychiatric ward, patients receive a basic structured psychiatric and medical assessment*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of patients with mental illness admitted to a psychiatric ward or other in-patient psychiatric service with psychiatric and medical assessment within 24 hours of admission divided by the number of admitted patients with mental illness	Revised recommendation 12.8: "On the day of their admission or as soon as they are well enough, patients receive a basic structured standard medical assessment and this is documented"	[30] (Royal College of Psychiatrists)[f]
Recommendation 23: Hospitals/ In-patient Services: access of wards to special services	Implement access of psychiatric wards to the following services: psychology, occupational therapy, social work, administration, pharmacy*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of the mental hospital and other in-patient units with access to psychology, occupational therapy, social work, administration and pharmacy divided by the total number of mental hospital wards	Recommendation 2.9: "The ward has access to sessional or part-sessional support from the following services: psychology, psychological therapies, occupational therapy, social work, pharmacy, dietetics, speech and language therapy"	[30] (Royal College of Psychiatrists)[f]
Recommendation 24: Hospitals/In-patient Services: detained patients procedures	Give detained patients prompt written information on their rights according to national rules and regulations*	Royal College of Psychiatrists Accreditation for Acute In-patient Mental Health Services*	Number of detained patients with written information on their rights within 12 hours divided by the number of detained patients without such information	Rewritten and generalised recommendation 12.5: "On the day of their admission or as soon as they are well enough, detained patients are, in accordance with section 132 of the MHA, given written information on their rights, rights to advocacy and second opinion, right to move hospital, rigt of access to interpreting services, professional roles and responsibilities, and the complaints procedures." MHA = mental health act	[30] (Royal College of Psychiatrists)[f]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 25: Elimination of waiting times for out-patient appointments	Implement processes to eliminate waiting times for out-patient appointments*	Single uncontrolled study+	Number of patients with a waiting time of 0 days divided by the number of patients with a waiting time > 0 days. From the literature, no normative standard for an acceptable maximal waiting time can be derived, because interindividual needs vary widely. The ideal target value should be zero days, since this study tried to eliminate waiting times	Elimination of waiting times for out-patient appointment reduces hospital admissions	[145]
Recommendation 26: Rehabilitation units	Implement the essential process requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance: Part 1 "Policies and Protocols" of Section 1 ("General Standards"); Part 15 "Initial Assessment and Care Planning", of Section 4 ("Timely and Purposeful Admission"), and Section 3 ("Safety")*	Expert opinion+	Number of psychiatric rehabilitation wards which fulfil all Type 1 recommendations of the Royal College of Psychiatrists AIMS guidance in Part 1 ("Policies and Protocols") of Section 1 ("General Sandards"), Part 15 ("Initial Assessment and Care Planning"), of Section 4 ("Timely and Purposeful Admission"), and Section 3 ("Safety") divided by the number of psychiatric rehabilitation wards	General recommendations on staffing and structures of rehabilitation in-patient units	[31]
Recommendation 27: Effective components of home-based treatment	Implement the effective process components of home treatment teams: small case load, regular visits at home, high percentage of contacts at home, responsibility for health and social care**	Cochrane search and expert opinion++	Number of mental healthcare facilities providing home treatment and follow a plan for regularly visiting at home, achieve at least a 50% rate of contacts at home,have responsibility for health and social care, and have small case loads of less than 50 patients per case manager, divided by those mental healthcare facilities providing home treatment and not fulfilling at least one of these requirements Explanatory note: "Responsibility for health and social care" means that responsibility for healthcare and social care rest within the same multidisciplinary team [21]	This indicator assesses whether home treatment services implement effective process components as identified in [21]. Note that the contact rate of 50% and the case load of 50 cases per case manager were chosen as expert opinions since there are no studies proving the efficacy or non-efficacy of home treatment for services not meeting a certain contact rate or with higher or lower numbers of cases per case manager. The studies show associations between case load and outcome and between high percentages of contact at home and outcome. Based on an analysis of the efficiency of assertive community treatment and other types of home-based treatment [21], the authors had shown that results varied widely giving an inconclusive picture. Therefore, this review set out to define the active components across the different home-based services and found that these two components were significantly associated with a reduction in hospitalization	[21]

Table 1 (*Continued*)

Topic	Recommendations and gradings[a]	Evidence base and gradings[b]	Quality indicators (proposals)	Comments	Source
Structure Recommendations					
Recommendation 28: Essential components of community mental health treatment	Implement the essential components of community mental health treatment: Multidisciplinary patient assessment, regular team reviews, monitoring and prescribing medication, psychological interventions, focus on continuity of care*	Cochrane review and expert opinion**	Number of persons in community mental healthcare who receive all of the following: multidisciplinary assessment, regular team reviews, monitoring and prescribing medication, psychological interventions and whose management plan has a focus on the continuity of care, divided by the number of all persons in community mental healthcare	These are the elements characteristic of community mental healthcare teams. Although there are no studies showing that high fidelity to these elements is significantly effective, the lack of studies pertaining to this question makes only an expert opinion available based on current practice	[97]
Recommendation 29: Active components of intensive case management	Implement the known active components of intensive case management, if intensive case management is used***	Cochrane review of 38 trials***	Combined index of the subscales "team membership" and "team structure organisation" of the Index of Fidelity to Assertive Community Treatment. As there is just a general correlation between this index and outcome, no cutoff can be given here	Model fidelity was associated with decreased hospital times	[43]
Recommendation 30: Organisational integration of psychiatric in-patient and out-patient services	Organisationally integrate psychiatric hospitals or psychiatric departments in general hospitals with psychiatric out-patient facilities including out-patient facilities in psychiatric hospitals, private practices and other ambulatory mental health services*	WHO Assessment Instrument for Mental Health Systems*	Number of mental hospitals organisationally integrated with mental health out-patient facilities divided by the total number of mental hospitals	Item 2.1.3: "Proportion of mental hospitals organisationally integrated with mental health out-patient facilities"	[143] (WHO-AIMS Version 2.2.)[c]

Although WHO-AIMS was mainly developed as an assessment instrument for middle- and low-income countries [118], it provides a range of indicators that appear also useful for European high-income countries, and these were transposed into recommendations for the European Guidance.

[a] The recommendations developed by the authors of this paper were graded following a three-part recommendation rating system: *: recommendation based mainly on expert opinion; **: recommendation based on expert opinion and/or unsystematic reviews and/or single uncontrolled or controlled, but unrandomized studies; ***: recommendation based on Cochrane reviews or other systematic reviews or single controlled, randomized studies.

[b] The evidence retrieved in the literature search was graded following a three-part evidence rating system: +: expert opinion; ++: unsystematic reviews; +++: Cochrane Review or other systematic reviews. A systematic review is a review which predefines search terms and databases, gives details about inclusion and exclusion criteria, and provides details about the number of retrieved, included, and excluded documents, plus a commented list of documents used for the purpose of the systematic review. All other types of reviews are defined here as "unsystematic". In recommendations where single trials were used as the best available evidence source, the evidence was graded as follows: +: single uncontrolled study; ++: single controlled, but unrandomized study; +++: single controlled, randomized study.

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

[d] http://www.ithaca-study.eu/outlines.html.

[e] http://www.euro.who.int/__data/assets/pdf_file/0008/96452/E87301.pdf.

[f] http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/aims.aspx. Internet sources c to f, last accessed on August 24, 2010.

specialised mental health services are necessary to cover the needs of all people with mental disorders. This cannot be studied in controlled trials, therefore this recommendation is founded on expert opinion, but it is based on recommendations from the WHO Mental Health Action Plan for Europe [140] and the Finnish Quality Recommendations for Mental Health Services [104].

3.1.1.2.4. Recommendation 6: Availability of technological equipment for assessment and treatment. Provide all state of the art evidence-based technological diagnostic and therapeutic equipment and services within 72 hours. This structural recommendation is based on the clinical experience that a thorough (preferably evidence-based) diagnostic workup in a person with a mental health problem may require a range of technical investigations. The time limit of 72 hours will be considered sufficient for non-acute cases. However, in acute cases, immediate referral to specialists providing these services may be required. An important aspect for the general quality of mental health services is whether they can provide access to all necessary diagnostic and therapeutic procedures in time. For instance, medical technologies like biochemical laboratory assessments including drug monitoring, electrocardiography, electroencephalography, neuroimaging (computed tomography, magnetic resonance imaging), or facilities for electroconvulsive treatment, neuropsychological testing, somatic counselling services and experimental-psychological investigations should be provided close to the help-seeking person. We could not identify any systematic studies comparing settings with and without the availability of such technology, and such research would ethically hardly be justifiable. Given the frequent mentioning of such technologies in evidence-based guidelines for the diagnosis and treatment of mental disorders, we felt it necessary to add this item to the guidance list as a prerequisite for any modern mental healthcare service.

3.1.1.2.5. Recommendation 7: Psychiatric Workforce. Create a sufficient and competent workforce ensuring an equitable distribution and develop specialist training streams. This recommendation should not only cover psychiatrists but any number of specialists necessary to supply a sufficient number of services with sufficiently qualified numbers of mental healthcare professionals with an equitable distribution over a region (see also the recommendation on the multiprofessionality of services). The ideal would be a quantitatively sufficient and qualitatively competent workforce depending on the need of the targeted region. This recommendation has an ethical background and was based on a corresponding recommendation by WHO [140] and the Finnish health authorities [104]. A large number of quality indicators could be developed but we focused on the numbers of psychiatrists in in- and out-patient settings per 100,000 people since this guidance mainly aims at optimizing mental healthcare by psychiatrists. Similar indicators may be developed for other professions like psychologists, social workers and nurses in order to ascertain availability and training to support access to adequate multiprofessional mental healthcare (see also Recommendation 4). An important but problematic issue would be the optimal number of psychiatrists or other mental healthcare professionals, which would be expected to be highly variable due to the available mental healthcare framework, the mix of mental healthcare services, the prevalence and incidence of mental disorders and the financial resources. Therefore, we could not give any concrete figures or limits for these quality indicators, but advise to use them in order to detect trends over time which may indicate a deterioration of service qualities if the indicator declines. Other pressing questions are the definitions of "sufficient" and "competent", and we suggest that mental healthcare planners decide on these definitions individually since these are normative concepts whose operationalisations will be highly dependable on the available resources, mental healthcare traditions and societal consensus in every country.

3.1.1.2.6. Recommendation 8: Catchment areas. Ensure that catchment areas/service areas are implemented as a way to organise mental health services to communities. This recommendation is expert opinion-based and follows a corresponding WHO recommendation [143]. This was deemed important for inclusion in the EPA Guidance since it will help to structure and analyse mental healthcare services in a given region also clarifying responsibilities for mental healthcare provision in a given country or area.

3.1.1.2.7. Recommendation 9: Day hospitals for people with acute mental disorders. Develop day hospital services for people with acute mental disorders. This recommendation is based on a Cochrane review [100] and the major sources of evidence were 9 randomized, controlled studies showing that caring for people in acute day hospitals can achieve substantial reductions in the number of people needing in-patient care, whilst improving patient outcome. This review only considered studies with acute day hospitals and patient characteristics were not further described. However, the definition of a "day hospital" in the sense of this Cochrane review was "diagnostic and treatment services for acutely ill patients who would otherwise be treated on traditional psychiatric in-patient units" [100]. Therefore, the conclusions from the Cochrane review were formulated by the authors to pertain to "acute mental disorders" for the purposes of this guidance. Marshall et al. analysed the effects of day hospital versus in-patient care for people with acute psychiatric disorders in their systematic Cochrane review. The conclusion was that acute day hospitals can reduce the number of patients requiring in-patient care and reduce costs. For patients who were judged suitable for day hospital care, the patient data indicated a more rapid improvement in mental state, but not in social functioning amongst people treated in the day hospital. There was no significant difference in readmission rates between day hospitals and controls and while the total hospital day numbers were unchanged, the relative distribution changed towards day hospital days [100] (evidence grade: systematic Cochrane Review). Another Cochrane Review [119] assessed the effects of day hospitals as an alternative to continuing out-patient care for people with schizophrenia and similar severe mental illnesses. The authors stated that day hospitals may help to avoid in-patient care, but they also point out that evidence is limited; there was a lack of some outcome parameters like "quality of life", "satisfaction", "healthy days" and "costs". Data on time spent as in-patient were poorly reported, data regarding allocation rates to hospital care were heterogeneous. There was no difference for loss to follow-up and findings on social functioning were equivocal. There was some indication for a reduction of the rate of unemployment. Different measures of mental state showed no convincing effect (evidence grade: systematic Cochrane review). No information is available as to the process components which are necessary for providing efficient day hospital services. A similar model of mental healthcare is day centre care, but the last Cochrane review found no sufficient studies to assess this type of service coming to the conclusion that pragmatic decisions should be taken if given the choice of using a day centre for mental illness [28]. Therefore, we have not added a recommendation for or against day centres in this guidance.

3.1.1.2.8. Recommendation 10: Psychiatric care for members of minority groups. Provide adequate psychiatric care facilities for linguistic, ethnic and religious minority groups. Given the multiethnicity of the European population and the free exchange of people between European countries, this expert opinion-based recommendation was derived from similar WHO recommendations [143]. It seems important to the developers of the EPA

Guidance since migration backgrounds are now common in a significant ratio of people in Europe and the nature of mental disorders makes it highly advisable to assure that mental healthcare is offered in the mother-tongue of any person affected by a mental disorder. In addition, individual ethnic and religious aspects of a mental disorder need to be respected, which may necessitate certain organisational provisions like special meals or time and space for religious ceremonies in in-patient settings. This, of course, may put a high organisational strain on mental healthcare service providers, but it is inevitable in order to ascertain a high service standard which meets the demands of people with mental disorders.

3.1.2. Specific structure recommendations

3.1.2.1. Microlevel recommendations.

3.1.2.1.1. Recommendation 11: Essential in-patient services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities"). We chose only the Type 1 recommendations, because according to the classification of recommendations in the AIMS guidance [30], failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. Type 2 recommendations are those that an accredited ward would be expected to meet and type 3 recommendations are standards that an excellent ward should meet or standards that are not the direct responsibility of the ward. This expert opinion-based recommendation serves to ascertain a minimum structural quality in selected staffing and facility hardware-centered areas of in-patient mental healthcare. It is based on the recommendation set for psychiatric wards developed by the Royal College of Psychiatrists [30]. We chose the AIMS guidance as our main source because it is available in English, is rather comprehensive and has a high face value. We wanted to be as explicit as possible in our recommendations without overwhelming the EPA Guidance by too many items, therefore we selected "staffing" and "environment and facilities" as the central elements. Other aspects of in-patient treatment covered by the AIMS guidance are dealt with in other recommendations of the EPA Guidance.

International experiences are limited in defining the essential in-patient structural requirements. A working group of Swiss chief psychiatrists agreed on 9 standards for in-patient psychiatric hospitals (these standards include handling critical processes like admission, treatment contract and discharge, dealing with risky situations, involuntary treatment [fixation, isolation, medication], evidence-based treatment, patient satisfaction, interdisciplinary cooperation, handling patient data, appraisal interviews, integrating medico-economical thinking and actions) (evidence grade: expert opinion). These standards can help to build up quality projects or to fulfil external quality requirements like those from EFQM or ISO [135]. The Finnish Mental Health Preparation and Monitoring Group and the UK Royal College of Psychiatrists' Centre for Quality Improvement have published standards for several mental health services in various settings (evidence grade: expert opinion). The patient questionnaires mentioned above and also the standard instruments of the Royal College of Psychiatrists can be recommended for quality assessments of psychiatric hospitals. No evidence-based consensus method to determine the optimal amount of in-patient beds or treatment places could be identified, we have therefore not made any recommendation for this question, and no studies addressed the question which were the effective process components for mental health in-patient services in general. Therefore, we by and large suggested to follow the Royal College of Psychiatrists recommendations for the structure and processes of in-patient mental health services [30] supplemented by the Finnish recommendations [104].

An important question when addressing the issue of structural requirements of in-patient mental health services was how to consider patients' views. A study in Germany aimed to identify aspects of care and treatment which patients considered important, and the degree of patient satisfaction with the services provided. The questionnaire developed for this study covered 22 areas of care and treatment. Patients distinguished between aspects they considered important and aspects they were satisfied with. Areas that were rated as highly important but received low satisfaction ratings included: medication, medical/psychiatric examinations and patient participation in treatment planning. Patient-staff relationships were rated as important and satisfactory. Patient-staff-relationships were also more important for patient satisfaction than the "hotel factor", which includes "ward accommodation" and "quality of food". The authors conclude that the patient survey can be used for quality improvement in psychiatric hospitals (evidence grade: uncontrolled study) [89]. The question remains open how much weight should be given to patients' perceptions and what other evidence should be considered. Gigantesco et al. [58] have also developed and evaluated a self-rating questionnaire for the routine assessment of patients' opinions and experiences of the quality of care in in-patient psychiatric wards. The ROQ-PW questionnaire (Rome Opinion Questionnaire for Psychiatric Wards') includes 10 items. The overall results of the study seem to indicate that this questionnaire is an adequate tool for evaluating patients' opinions on the care provided in in-patient psychiatric wards, which could be slightly modified for use in other settings, such as day centres, residential facilities and day hospitals (evidence grade: uncontrolled study). As it does not involve observer-based assessments, it avoids observer biases.

3.1.2.1.2. Recommendation 12: Essential out-patient services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance for in-patient services (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities"). This is an expert opinion-based recommendation analogous to the corresponding in-patient services recommendation (Recommendation 10). It was developed by the authors of this guidance in order to ascertain that some basic structural requirements are also supplied for the orientation and assessment of mental health out-patient services. Since there was no generic out-patient recommendation available, we suggest to use the applicable AIMS in-patient recommendations in analogy [30]. No comparative suggestions for essential general components of out-patient services are available in Europe. One important factor could be the number of psychiatrists in out-patient services and the number of out-patient mental healthcare facilities, but the necessary numbers depend on a large number of factors like the degree of dehospitalisation in a given country. Therefore, no specific recommendations for the number of in-patient beds and out-patient treatment places, or the optimal mix between these two areas of mental healthcare in a given mental healthcare system, are given here.

3.1.2.1.3. Recommendation 13: Essential rehabilitation services structural requirements. Implement the essential structural requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS guidance (Part 2) "Staffing" of Section 1 ("General Standards") and Section 4 ("Environment and Facilities"). This is a recommendation analogous to recommendations 11 and 12, but now with a more specific reference to the AIMS guidance developed for in-patient rehabilitation units [31]. The developers of the EPA Guidance think that the same standards used for psychiatric in- and out-patient services should also be applied

to special rehabilitation units and although the AIMS guideline was developed for in-patient rehabilitation units, it may be used in analogy for out-patient rehabilitation units as well. Thus, the rationale for its inclusion is similar as for recommendations 11 and 12. We could not identify specific studies on comparative analyses of different service structures or specific processes in rehabilitation mental healthcare. Certain measures like supported employment or cognitive training are effective in improving rehabilitation outcome especially in schizophrenia and other severe mental illnesses (evidence grade: controlled studies) [15,23,27,44,102]. The components of such complex interventions like supported employment which are most important for therapeutic effects are manifold, but model fidelity appears to play a role and the mental healthcare setting in which these measures are applied is a major factor (evidence grade: systematic review) [15]. The beneficial effects of supported employment are partly dependent on the country in which the method is applied and the generalisability of the beneficial effects of cognitive training to diverse settings and countries remains to be determined. Thus, while it appears reasonable to assume that the structural measures for providing supported employment and cognitive training in mental health rehabilitation should be provided, it appears premature to suggest this as an EPA Guidance. Considering the lack of studies on structure or process effectivity components, we chose to recommend to implement the Royal College of Psychiatrists standards for psychiatric wards (expert opinion recommendations) also for rehabilitation services. These were designed for in-patient rehabilitation units and we could not identify any similarly systematic specific structure or process recommendations for out-patient rehabilitation services.

3.1.2.1.4. Recommendation 14: Community mental health teams for people with severe mental illnesses. Develop a system of community mental health teams for people with severe mental illnesses and disordered personality. This recommendation is based on a Cochrane Review with three randomised controlled studies [97]. Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. "Personality disorder" was not closer defined in this study, but the term "personality disorder" was used as a search term for the identification of studies of putative relevance for this Cochrane review. Especially the Italian experience has provided a wealth of data regarding the efficiency of community-based mental healthcare [6,125]. While substantial reductions in the numbers of hospital care patients have been achieved, community mental health services were established and more frequently used (evidence grade: systematic review) [6]. While residential facilities have been established more or less completely, general hospital psychiatric units are still being added [95]. The spectrum of patients treated in the different facilities and the range of facilities offered shows considerable regional variation even thirty years after the start of the Italian reforms with shortages of public in-patient beds in some regions [35,95]. While the public in-patient sector declined, the private sector remained at the pre-reform level so that the number of private in-patient beds per 10,000 population now exceeds the number of public beds [35]. A major lesson here was that de-institutionalisation can only succeed when the appropriate community mental health services are simultaneously scaled up. From a more general view, the ways of implementing community-based mental health services vary widely between countries prohibiting premature generalisations. A systematic review of community-based care services came to the conclusion that the psychiatric workforce plays a decisive role when outcome variance was to be explained. The presence of a psychiatrist, for example, was considered to be essential for the success of assertive community treatment (ACT) teams. The same applied to staffing levels, the availability of a minimum number of psychiatric beds and the compliance with elementary principles of the ACT service model ("model fidelity") [52] (evidence base: systematic review). The World Psychiatric Association has recently summarized the global experiences of de-institutionalisation in mental healthcare and provided a guidance on steps, obstacles and mistakes to avoid in the implementation of community mental healthcare [130]. Besides financial and organisational aspects, not neglecting mental disorders other than schizophrenia in community mental healthcare and paying due attention to patients' physical health appear as important additional factors to be considered. A new trend is the introduction of compulsory community treatment and involuntary out-patient treatment for people with severe mental disorders. A recent Cochrane review showed that only few studies were available and that this results in no significant difference in service use, social functioning or quality of life compared with standard care, but that people receiving compulsory community treatment were less likely to be victims of crime [80]. Given this small evidence base, we have not formulated guidance recommendations for this special type of out-patient mental health service.

3.1.2.1.5. Recommendation 15: Intensive case management. Implement Intensive Case Management services for severely mentally ill persons with high hospital use. This recommendation is based on a Cochrane review of 38 studies and although the intervention effects seemed weak, the subgroup of severely mentally ill persons benefited from intensive case management (reduced hospitalisations, increased retention in care).

3.1.2.1.6. Recommendation 16: Integrated care models. Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers. This recommendation is derived from the conclusions of a review [52] and based on results from studies and expert opinion.

3.2. Process recommendations

3.2.1. General process recommendations

3.2.1.1. Mesolevel recommendations.

3.2.1.1.1. Recommendation 17: Implementation of evidence-based medicine. Follow the rules of evidence-based medicine in diagnostic and therapeutic decisions. This recommendation was derived from a review and single studies (summarized in [147]). This summary was focused on guideline implementation and although the evidence base is small, this is the best evidence that is available and therefore this recommendation can be made in general.

3.2.1.2. Microlevel recommendations.

3.2.1.2.1. Recommendation 18: Safety procedures. Implement operational policies in mental health facilities to ascertain patient and staff safety, e.g., with efficient alarm systems, and to manage violent patient behaviour. This recommendation is based on expert opinion following the Royal College of Psychiatrists AIMS recommendation [30]. It was included because it addresses an important issue in mental healthcare and although no studies are available, active management of such problematic situations seems the best evidence-based practice. The prevention of deep vein thrombosis, for example, is important for secluded or restrained patients with mental illnesses and it is essential to establish a detailed management plan on seclusion and fixation taking into account the medical risks of physical restraint [37]. The AIMS recommendation also includes suggestions on how to deal with critical situations like the necessity for restraint, with a

special emphasis on those persons with medical conditions which may increase the likelihood of injury during periods of restraint (recommendations 12.10 and 20.6 in [30]).

3.2.1.2.2. Recommendation 19: Informed consent. Ascertain that the choice of treatment is made jointly by the patient and the responsible clinician based on an informed consent. This expert opinion-based recommendation was derived from a medication-related AIMS recommendation [30] and generalized to include all treatment decisions – not just medication decisions.

3.2.1.2.3. Recommendation 20: Monitoring of physical illness and access to general and specialised medical services. Monitor physical illness and provide timely access to general and specialised medical services when necessary. This recommendation is based on expert opinion and on studies indicating the high prevalence of physical illness in persons with mental disorders [36,38,39].

3.2.2. Specific process recommendations

3.2.2.1. Microlevel recommendations.

3.2.2.1.1. Recommendation 21: Hospitals/in-patient services: basic requirements. Implement the essential process requirements as outlined as Type 1 recommendation by the Royal College of Psychiatrists AIMS (Section 2 "Timely and Purposeful Admission" and Section 3 "Safety") [30]. This expert opinion-based recommendation serves to ascertain that in two essential elements of in-patient processes, namely admission procedures and safety, basic requirements are met.

3.2.2.1.2. Recommendation 22: Hospitals/in-patient services: admission procedures. Ensure that on the day of their admission to a psychiatric ward, patients receive a basic structured psychiatric and medical assessment. This recommendation follows a similar recommendation in the AIMS guidance [30] and is based on expert opinion. It has a high face validity and its fulfilment needs to be ascertained since it is essential to in-patient services quality. A question that we also addressed was the necessary length of hospital stays. A Cochrane review by Alwan et al. [5] had identified six randomized trials comparing the effects of long vs. short stays and that the persons with short stays were more likely to be employed. However, given the lack of systematic studies and the large intra- and interindividual variability of the presumed optimal length of stay, we did not include any recommendation as to the necessary duration.

3.2.2.1.3. Recommendation 23: Hospitals/in-patient services: access of wards to special services. Implement access of psychiatric wards to the following services: psychology, occupational therapy, social work, administration, pharmacy. This expert opinion-based recommendation was developed following a similar AIMS recommendation [30] and reflects the necessity of multiprofessional service provision of people with mental disorders.

3.2.2.1.4. Recommendation 24: Hospitals/in-patient services: detained patients procedures. Give detained patients prompt-written information on their rights according to national rules and regulations. This expert opinion-based recommendation was developed following a similar AIMS recommendation [30] and shall assure that in this very sensitive therapeutic setting, essential legal standards are adhered to.

3.2.2.1.5. Recommendation 25: Elimination of waiting times for out-patient appointments. Implement processes to eliminate waiting times for out-patient appointments. Although this recommendation is evidence based from only a single uncontrolled study [145], it provides quality assurance for a very important field dealing with the continuity and accessability of mental healthcare.

3.2.2.1.6. Recommendation 26: Rehabilitation units. Implement the essential process requirements as outlined as Type 1 recommendations by the Royal College of Psychiatrists AIMS guidance: Part 1 "Policies and Protocols" of Section 1 ("General Standards"); Part 15 "Initial Assessment and Care Planning" of Section 4 ("Timely and Purposeful Admission") and Section 3 ("Safety"). This is a recommendation serving to ascertain that basic process requirements are met in rehabilitation service units. It is expert opinion-based [31] and provides a selection of essential requirements out of a larger and more comprehensive list.

3.2.2.1.7. Recommendation 27: Effective components of home-based treatment. Implementation of the effective process components of home treatment teams are included: small case load, regular visits at home, high percentage of contacts at home, responsibility for health and social care. This indicator assesses whether home-treatment services implement effective process components as identified in [21]. The studies show associations between case load and outcome and between high percentages of contact at home and outcome. Based on an analysis of the efficiency of assertive community treatment and other types of home-based treatment, it was shown that results varied widely giving an inconclusive picture. A recent Cochrane review dealing with home crisis intervention came to the conclusion that home care leads to a reduction of repeated hospital admissions, reduces loss to follow-up and reduces family burden, and increases patient and relatives satisfaction, but that more evaluative studies were needed [76]. No effects on mental state or mortality were found. For older people with mental health problems, a systematic review by Toot et al. [131] came to the conclusion that crisis resolution/home treatment teams were effective in reducing the number of hospital admissions, but that evidence was inadequate for drawing conclusions about length of hospital stay and maintenance of community residence. A randomized controlled trial concluded that mobile crisis team intervention to enhance linkage of suicidal emergency department patients to out-patient psychiatric services had no positive effects on patient-relevant outcomes although it increased the contact rate [35]. The evaluation of home-based mental healthcare services is made difficult due to the large variation of the kinds of services provided [20]. Burns et al., however, identified the following six components as the effective ingredients of home-based care for mental illness based on a Cochrane search: smaller case loads, regularly visiting at home, a high percentage of contacts at home, responsibility for health and social care, multidisciplinary teams and a psychiatrist integrated in the team [21]. These were chosen as structural or process recommendations as appropriate.

3.2.2.1.8. Recommendation 28: Essential components of community mental health treatment. Implement the essential components of community mental health treatment. If implemented, community mental health treatment should include effective elements. This includes the following process elements: multidisciplinary patient assessment, regular team reviews, monitoring and prescribing medication, psychological interventions, focus on continuity of care. As a conclusion of 6 controlled studies from England, Australia and Canada, community mental health teams had no added effect on psychiatric symptoms. Admissions to hospitals were possibly lower. Social adjustment and patient satisfaction levels were better [52]. Malone et al. [97] evaluated the effects of community mental health teams for people with serious mental illnesses versus non-team standard care (evidence base: systematic Cochrane review). They concluded that community mental health teams were superior in promoting greater acceptance of treatment and may be superior in reducing hospital admission and avoiding death by suicide. As aforementioned, the WPA guidance discusses this issue in more detail [96,130]. For the EPA guidance recommendation, the positive effects on treatment acceptance suggest the usefulness of implementing CMHT services and to include the following process elements: multidisciplinary patient assessment, regular team reviews, monitoring and prescribing medication, psychological interventions, focus on continuity of care. These are the elements characteristic of CMT teams. Although

there are no studies showing that high fidelity to these elements is significantly effective, the lack of studies pertaining to this question makes only an expert opinion available based on current practice [100].

3.2.2.1.9. Recommendation 29: Active components of intensive case management. Implement the known active components of intensive case management, if intensive case management is used. If implemented, intensive case management should follow the rules outlined by assertive community treatment procedures. This recommendation is based on a Cochrane review of 38 studies showing that model fidelity was associated with reduced hospital times [43]. The available evidence suggests that intensive case management is most effective to reduce the numbers of days in psychiatric hospitals in the most severely affected people with mental illness with high-frequency use of mental health services [23] (evidence base: systematic review). There was a global positive effect on social functioning. The effects on mental state and quality of life, however, remained uncertain. Intensive Case Management seems to be most effective in those with a severe mental illness with high levels of hospitalisation rates and in those who receive this service in a setting with high fidelity to the original service construct. Marshall identified several critical issues in that terminology in this field was often confusing and that the adherence to the definitions of complex interventions was of central importance. Also, the choice of control group was very decisive for the net effect of such complex interventions, a problem which makes meta-analyses inherently difficult. Similarly, Burns et al. reported that European studies on intensive case management failed to replicate the highly significant advantages over standard care demonstrated in early American and Australian work [19]. In the EPA guidance, intensive case management is therefore only recommended for those with severe mental illness and high hospital use (structure recommendation), and a high degree of model fidelity to standardised model constructs like assertive community treatment or case management is necessary. A recent controlled trial concluded that assertive community treatment was effective for improving one-year outcome in schizophrenia patients [88] (evidence base: controlled study). Interventions in this class of mental health services were assessed in a recent Cochrane review by Dieterich et al. [43] with the main result that such services reduced hospitalisations compared to standard care, increased retention in care and reduced loss to follow-up. The results on mental state outcomes were considered equivocal. Mortality or suicidality were not changed compared to standard care. Social functioning results varied and data for quality of life were weak and inconclusive. A close adherence to the assertive community treatment model appeared to benefit the outcome "decreasing times in hospital", which was most pronounced in services with a high baseline hospital use rate in the population. In summary, Dieterich et al. [43] concluded that intensive case management was effective in improving process variables, but less so – if any – outcome variables. The conclusion for this guidance is to suggest the implementation of such services only for severely ill persons with high hospital use (structure recommendation) and to suggest to use model fidelity as a process recommendation.

While preadmission out-patient care appears to lead to reduce hospital stay times [33] (evidence base: observational study in different settings with and without preadmission out-patient care) and seems to be a quality indicator which may be dealt with by a case manager, it is questionable in how far the number of readmissions is a quality indicator for the mental healthcare system as a whole, but readmission frequency appears to be a quality indicator of the previous hospitalisation [24] (evidence base: naturalistic retrospective analysis) and there is only limited information on how to prevent readmissions [47]. Meta-analyses came to similar, but in some parts contradictory results (especially regarding the efficacy of case management to reduce symptom scores) [23,122,150].

3.2.2.1.10. Recommendation 30: Organisational integration of psychiatric in-patient and out-patient services. Develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers. This recommendation is based on a conclusion from a review, which, however, also implied expert consensus [52]. Generally, the integration of mental health services is considered to be important [52], and a recent review came to the conclusion that integrated care models could improve outcome compared with conventional services [50] (evidence base: systematic review). However, only improving access does not automatically improve outcomes in integrated care models as shown in a randomized controlled study for mental healthcare in older patients from minority groups [7]. Regarding care pathways, there is relatively little published in relation to mental health [49]. Mainly based on recommendations in [52] (evidence base: systematic review), we here suggest to develop and implement integrated models of cooperative community care providing scientific evidence-based services with joint budgetary responsibility of participating service providers (structure recommendation) and to organisationally integrate mental health hospitals with mental health out-patient facilities (based on an expert opinion-based WHO-AIMS recommendation).

4. Conclusions and perspectives

The main intention of this guidance is to promote the optimisation of mental healthcare service structures in Europe. There is a need to investigate the relationship between particular components and contents of mental health services and outcome, in order to increase the knowledge of what is effective in improving mental health and to provide cost-effective measures in mental health services [64].

When reviewing the available studies, we noticed that some areas like "acute day hospitals" were much researched, but are not very common across Europe, while essential questions like whether electroconvulsive treatment as one of the "state of the art" treatments is available have only begun to become the object of systematic studies. Thus, there is a certain discrepancy between the large diversity of mental health service structures that have evolved in Europe and the objects of mental healthcare research, which – as we strived to develop evidence-based recommendations – is also reflected in our recommendations. The recommendations may therefore unjustly privilege mental healthcare structures like home-based treatment, assertive community treatment or day hospitals although an immediate transfer to European countries other than those in which these services have been studied may neither be feasible nor warranted. This limitation clearly underscores our point that these recommendations are not cookbook prescriptions for mental healthcare planning, but rather a reflection of the current state of the art, which needs to be critically assessed for every European country. Pan-European studies comparing different models of mental healthcare services are necessary to further develop European recommendations for mental healthcare. These recommendations cannot be a master plan for mental health services planning, but may provide an initial panel of recommendations, which will now need to be tested in the European countries. As quality indicators are also given here, we recommend to establish a European study group which will assess whether the implementation of these recommendations leads to optimized mental healthcare. Another aspect was that for some essential structural components like the

necessary number of psychiatric beds in a certain region, no evidence-based figures are available. In Germany, for example, this number is determined by the Hill-Burton formula, which is based on the US-American Hill Burton Act of 1946. This Act set standards for the number of hospital beds if federal funding was to be allocated to a certain provider. Later, it became useful to determine the number of beds in psychiatric hospitals. However, it is more of a guidance for political decisions in the mental healthcare market rather than an evidence-based guideline, and does not help individual psychiatric hospitals to determine the number of beds needed. Its formulation according to the German Hospital Association [57] is:

$$\mathrm{HBF} = \frac{\mathrm{E} \times \mathrm{KH} \times \mathrm{VD} \times 100}{\mathrm{BN} \times 1000 \times 365}$$

HBF ("Hill Burton Formula") is the number of beds needed for a given population with E as the population number. KH is the number of hospital cases multiplied with 1000 and divided by E, VD is the average number of hospital days per case and BN is the degree of bed occupancy in percent.The complexity and diversity of the mental healthcare systems and structures in European countries makes it difficult to compare them. We tried to overcome this problem by formulating general principles but avoiding too specific recommendations. Some mental healthcare service structure analyses are only published in the local language, which limits access in other countries. They also often lack strict methodological criteria. We focussed on English and German language papers which introduces language bias to our study, but reviewing all European mental healthcare systems was beyond the scope of this project. It now appears necessary to also review the current mental healthcare systems and identify studies which may have been published in local languages only with a view to adapt additional recommendations. Furthermore, such a study should identify areas of mental healthcare research which would be feasible in the pan-European setting and could become a task of the EPA. Attitudes in society at large towards mental ill-health need to be taken into consideration when assessing mental healthcare structures [117]. These will influence policy makers and therefore an EPA-guided survey of these attitudes would additionally be necessary. One also needs to take into consideration that there are new trends in some European countries away from the all-encompassing, transsectoral community social psychiatric models introducing a new focus on expert psychiatric clinics like clinics for affective disorders, suicide prevention clinics, clinics for treatment refractory schizophrenia etc., linked to both psychiatric intensive beds in wards of general hospitals and outreach teams for chronic patients, with less participation of psychiatrists in assertive community treatment teams [108]. While there is some evidence suggesting a link between the numbers of treated patients and the achievable quality of mental healthcare, these interrelationships are not yet clear and are in need of further study [46]. These developments will make timely updates of the EPA guidance necessary warranting a continuous updating process to be initiated by EPA. Measures should be developed to provide standard tools to assess the efficacy and efficiency of mental health services. Currently, measures of the "content of care" are being developed, e.g., measures to assess whether a person affected by a mental disorder receives the needed social, psychological and physical/pharmaceutical interventions, and if general care organisation is adequate [97,99]. Future updates of this recommendation may need to include such measures once more data on their use become available.There is a pressing need for high-quality, multinational mental healthcare research studies to identify the most effective components of mental healthcare and the EPA is strongly advised to initiate such European research initiatives. The EPA guidance project can be an important step in this direction by providing an overview over the – quantitatively and qualitatively somewhat limited – evidence. International studies are needed which address the issue of the most effective components of mental health service structures and processes with a view to obtain a more solid evidence base for any recommendations about mental health services in Europe. There are only few studies which analyse the impact of mental healthcare structural parameters on patient outcomes. Also, patient outcome is inevitably influenced both by structure quality and process quality. While processes and structures are generally taken as important areas of quality assurance, assessing the outcome of mental healthcare is a third important area and is often used as a readout of the effects of implementing quality assurance measures in mental healthcare structures and processes [42]. However, there is a scarcity of studies relating outcome to structures, while there is a large number of studies assessing the outcomes of specific therapeutic processes. The latter, however, have only limited usefulness for general guidance recommendation pertinent to all European countries and all psychiatric disorders. Still, improving the structures of mental health services may have "downward" effects on processes and outcome [63]. We addressed this complex interrelationship by structuring the recommendations accordingly hoping to clarify which parts of the mental healthcare system are addressed by every individual recommendation.The interventions relevant to mental healthcare structures and processes reviewed in this guidance are mainly of the psychosocial type and do not deal with isolated interventions, with some notable exceptions like the EQOLISE study to assess the efficacy of supported employment [22]. We were challenged by the fact that no standardized assessment procedure was available for interventions like reducing waiting times in out-patient settings or introducing complex service structures or service processes like day hospitals or community mental health teams. We regard the suggestions on the grading of evidence of public health interventions published by a NICE committee as a good starting point for the development of our recommendation grading and evidence rating system [133], and attempt to solve this problem by devising a rating/grading system adapted to the purposes of the EPA guidance recommendations. The generalisability of some recommendations may be highly questionable and will have to be assessed for every European country. The EQOLISE study on supported employment was one of the European multinational mental healthcare studies identified here and showed clear differences of the results in different European countries, which seem to be dependent on the baseline unemployment rate and the social services available besides the intervention method [22]. An important aspect is the comparator in any studies dealing with the effects of novel mental healthcare methods. If "care as usual" is used, context-dependent factors will severely limit the generalisability of any research results. Large-scale international studies are warranted to provide evidence that can be used for developing European recommendations. Therefore, critically assessing the transferability of any study results and resulting recommendations to individual countries must become the task for a future update and the truly pan-European expert panel to be included then. Psychiatry as a medical specialty is constantly undergoing changes following scientific progress which bears upon psychiatric diagnostic or therapeutic procedures. An important current trend that follows from the progress in neurobiology and psychology is to centre psychiatric diagnosis and treatment on the assessment of brain-behavioural functions and their disturbances in mental disorders ("modular psychiatry"; [54]). Neurobiological and psychological models inform psychiatric treatment and recent progress in the psychotherapy of psychotic symptoms is based on such information from

neurobiology and psychology [56]. Such processes will make more sophisticated diagnostic and therapeutic procedures possible. Introducing sub-specialisations may lead to differentiated training programs for those medical students and residents who are more interested in the social psychiatric community-based approach, and more specialised training programs for those becoming high-level psychiatric specialists working in psychiatric expertise medical centers. This could also be a way to attract more medical students into psychiatry as a medical specialty and a medical career. The World Psychiatric Association recently compiled a review on the stigmatisation of psychiatry and psychiatrists, and ways to overcome them [117]. Sharpening the profile of psychiatry as a medical specialty and implementing structures of mental healthcare that foster a medical approach may be important to recruit more highly motivated medical students into the field [108]. Continuous updates of the EPA Guidance will be useful to consider future demographic changes and neuroscientific advances pertinent to mental healthcare. In conclusion, we suggest 30 recommendations for the quality of mental healthcare services accompanied by a corresponding set of quality indicators to assess the degree of implementation of these recommendations. In perspective, with the support of continuous updates, the recommendations will hopefully advance the development of optimal mental healthcare services in Europe in the short and long-term future.

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Lessons from the English Experience

THE QUEEN'S ANNIVERSARY PRIZES
FOR HIGHER AND FURTHER EDUCATION
2009

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Institute of Psychiatry
at The Maudsley

World Health Organisation
Collaborating Centre

KING'S College LONDON
Founded 1829
University of London

Plan

1. Recent mental health policy in England

2. Implementation in South London

3. Lessons learned

Plan

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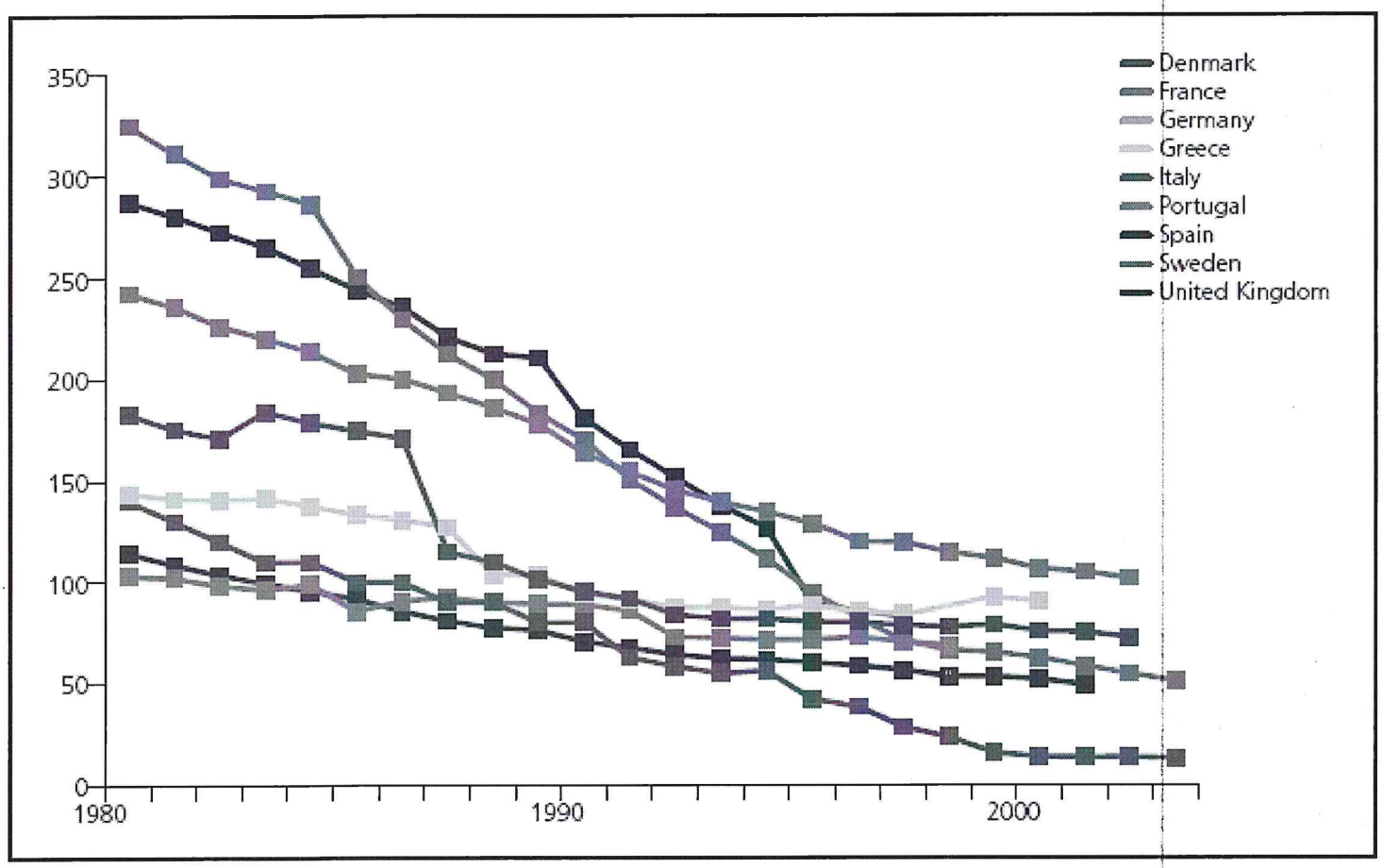
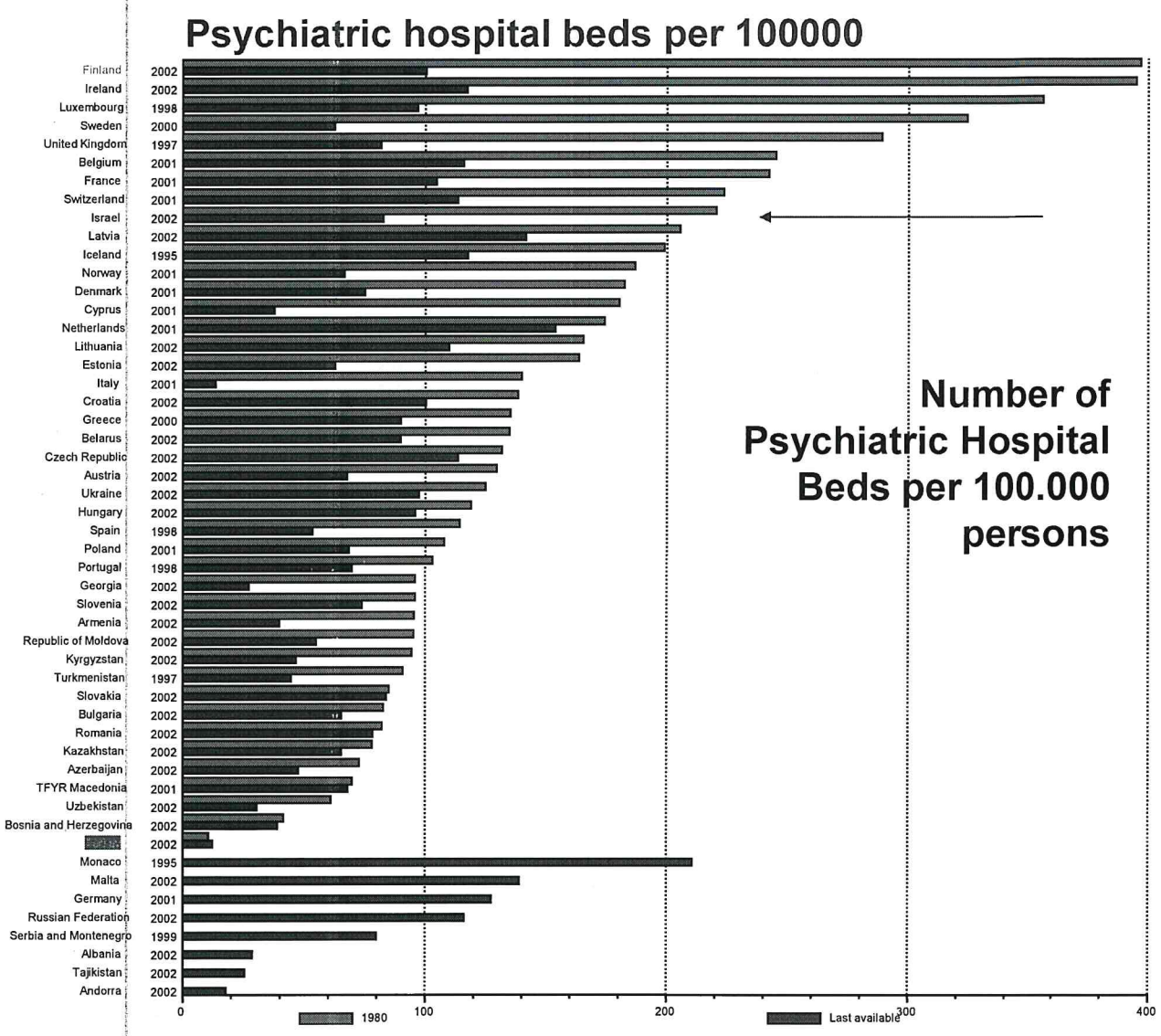
Psychiatric hospital beds per 100,000 – selected EU-15 countries, 1980-2003



Source: HFA 2006


Psychiatric hospital beds per 100000
Finland 2002
Ireland 2002
Luxembourg 1998
Sweden 2000
United Kingdom 1997
Belgium 2001
France 2001
Switzerland 2001
Israel 2002
Latvia 2002
Iceland 1995
Norway 2001
Denmark 2001
Cyprus 2001
Netherlands 2001
Lithuania 2002
Estonia 2002
Italy 2001
Croatia 2002
Greece 2000
Belarus 2002
Czech Republic 2002
Austria 2002
Ukraine 2002
Hungary 2002
Spain 1998
Poland 2001
Portugal 1998
Georgia 2002
Slovenia 2002
Armenia 2002
Republic of Moldova 2002
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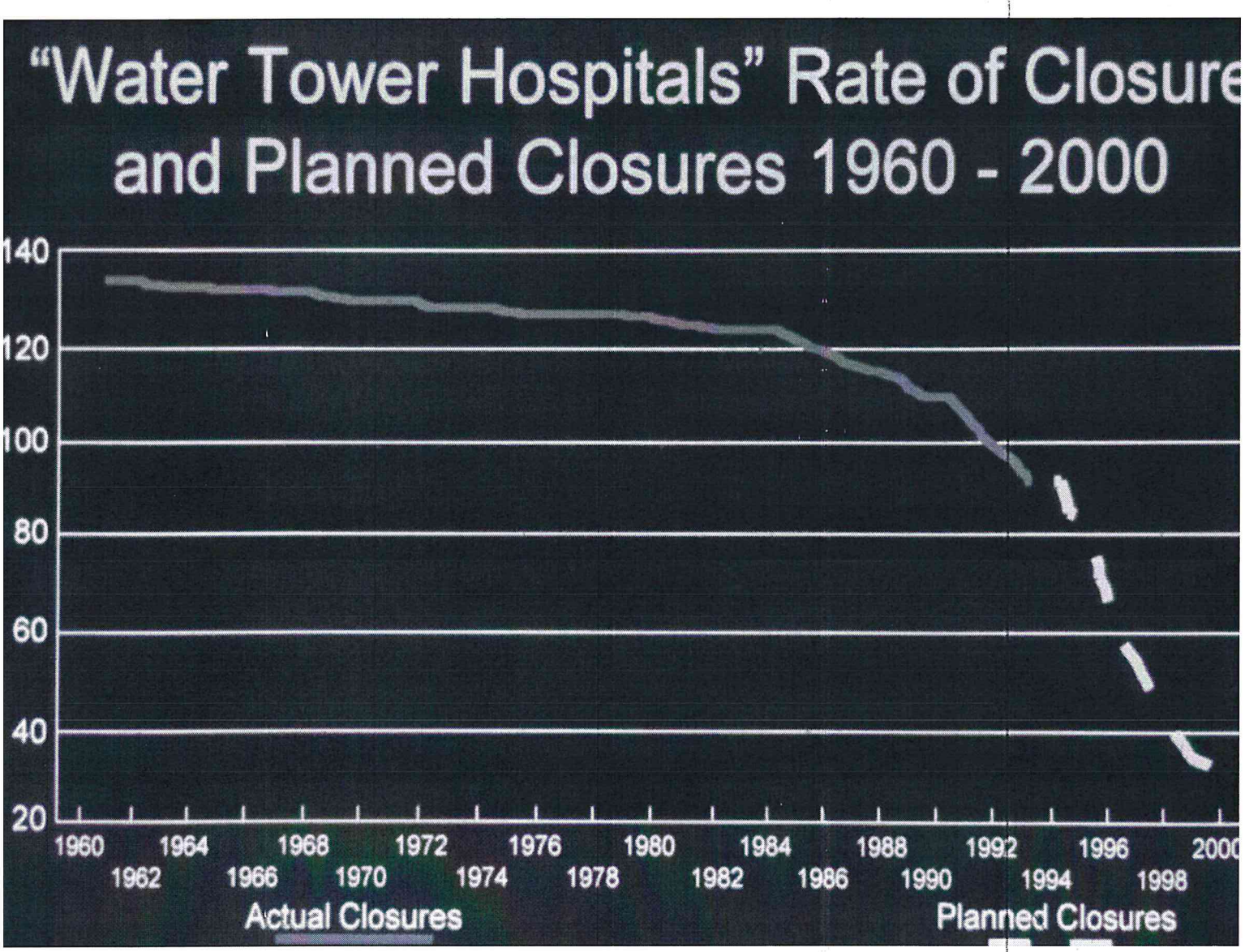
Turkmenistan 1997
Slovakia 2002
Bulgaria 2002
Romania 2002
Kazakhstan 2002
Azerbaijan 2002
TFYR Macedonia 2001
Uzbekistan 2002
Bosnia and Herzegovina 2002
2002
Monaco 1995
Malta 2002
Germany 2001
Russian Federation 2002
Serbia and Montenegro 1999
Albania 2002
Tajikistan 2002
Andorra 2002
0
100
200
300
400
1980
Last available
Number of Psychiatric Hospital Beds per 100.000 persons


"Water Tower Hospitals" Rate of Closure
and Planned Closures 1960 - 2000
140
120
100
80
60
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1960
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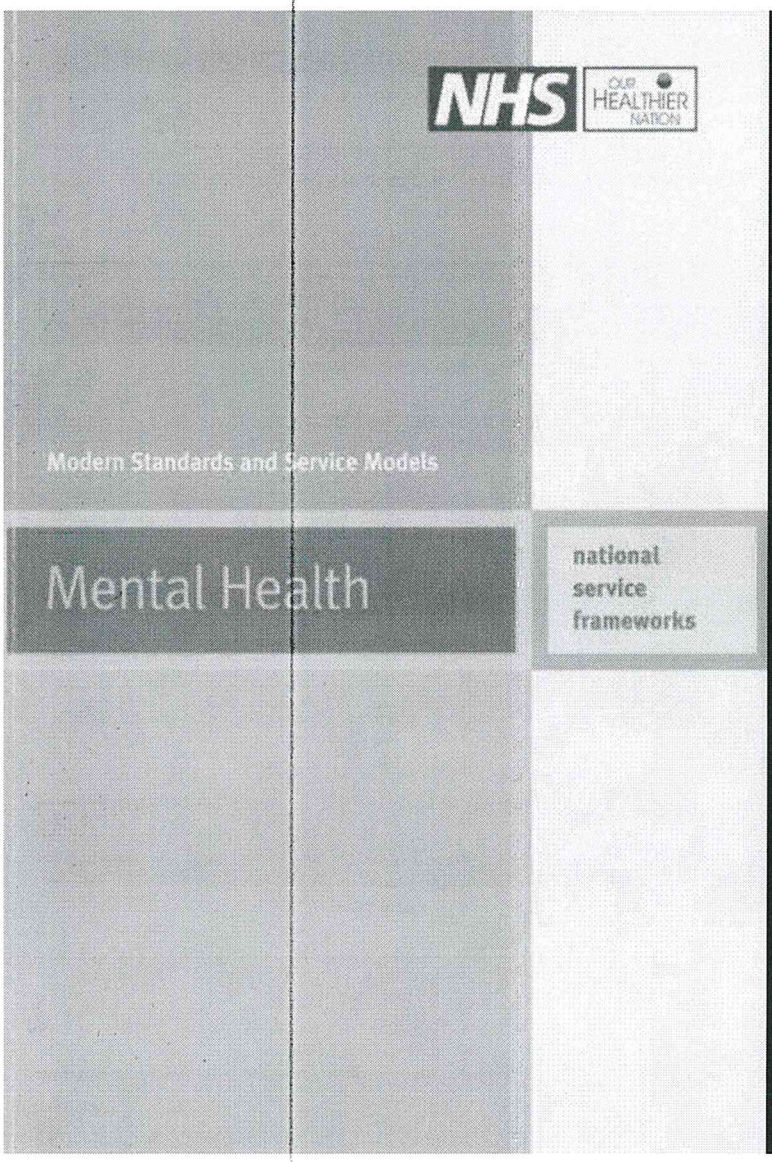
Actual Closures
Planned Closures



Written 1998

Published 1999

Operational 1999-2009

Web site for UK Mental Health Policy

www.doh.gov.uk/mentalhealth

Scope

The National Service Framework for Mental Health will help drive up quality and remove the wide and unacceptable variations in provision. It:

- sets national standards and defines service models for promoting mental health and treating mental illness
- puts in place underpinning programmes to support local delivery
- establishes milestones and a specific group of high-level performance indicators against which progress within agreed timescales will be measured

Participants/Stakeholders

- 70 people in 8 working groups
- 5 months intensive work
- including: carers, Department of Health policy makers, GPs, managers, NGOs, nurses, occupational therapists, psychiatrists, psychologists, researchers, service users, social workers- all felt underrepresented!
- a long weekend to reach consensus on agreed fundamental principles on which to build details of new national plan

Guiding Values and Principles

People with mental health problems can expect that services will:

- Involve service users & carers in planning and delivery of care
- Deliver high quality treatment and care which is known to be effective and acceptable
- Be well suited to those who use them and non discriminatory
- Be accessible so that help can be obtained when and where it is needed
- Promote their safety and that of their carers, staff and the wider public
- Offer choices which promote independence
- Be well co-ordinated between all staff and agencies
- Deliver continuity of care for as long as it is needed
- Empower and support their staff
- Be properly accountable to the public, service users and carers

Core Principles and Rights

S. Africa (Dept. of Health)	UK (Dept. of Health)	USA (Nat. Inst. of Med.)
Disclosure of info. Rights to representation	Involve consumers	Patient centred
	Effective & acceptable	Effective & efficient
Admission to estabishmt	Accessible	Timely
Unfair discrimination	Non Discriminatory	Equitable
Respect	Promote safety	
Consent	Choice	
Dignity & privacy	Co-ordinated	
Exploitation & abuse	Empower staff	
	Continuity	

Types of Evidence

Type I	≥ 1 good systematic review
Type II	≥ 1 good RCT
Type III	>1 intervention study (no randomisation)
Type IV	>1 well designed observational study
Type V	expert opinion, including the opinion of service users and carers

National standards and service models

Standards set in five areas:

Standard 1	Mental health promotion
Standards 2 & 3	Primary care/service access
Standards 4 & 5	Effective services for SMI
Standard 6	Caring about carers
Standard 7	Preventing suicide

Standard 1
Mental Health Promotion

Health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion

Standard 2
Primary Care and Access to Services

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it

Standard 3
Primary Care and Access to Services

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care
- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services

Standard 4
Severe Mental Illness (a)

All mental health service users having case manager should:

- receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk

continued...

Standard 4
Severe Mental Illness (b)

- have a copy of a *written* care plan which:
  - includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator
  - advises their GP how they should respond if the service user needs additional help
  - is regularly reviewed by their care co-ordinator
  - be able to access services 24 hours a day, 365 days a week

Standard 5
Severe Mental Illness (a)

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place, which is:
  - in the least restrictive environment consistent with the need to protect them and the public
  - as close to home as possible

Continued...

Standard 5
Severe Mental Illness (b)

- a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis

Standard 6 Caring about Carers

All individuals who provide regular and substantial care for a person with a Care Co-ordinator should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- have their own written care plan which is given to them and implemented in discussion with them

Standard 7 Preventing Suicide (a)

Local health and social care communities should prevent suicides by:

- implementing Standards 1-6

Early Intervention (EI) in Psychosis

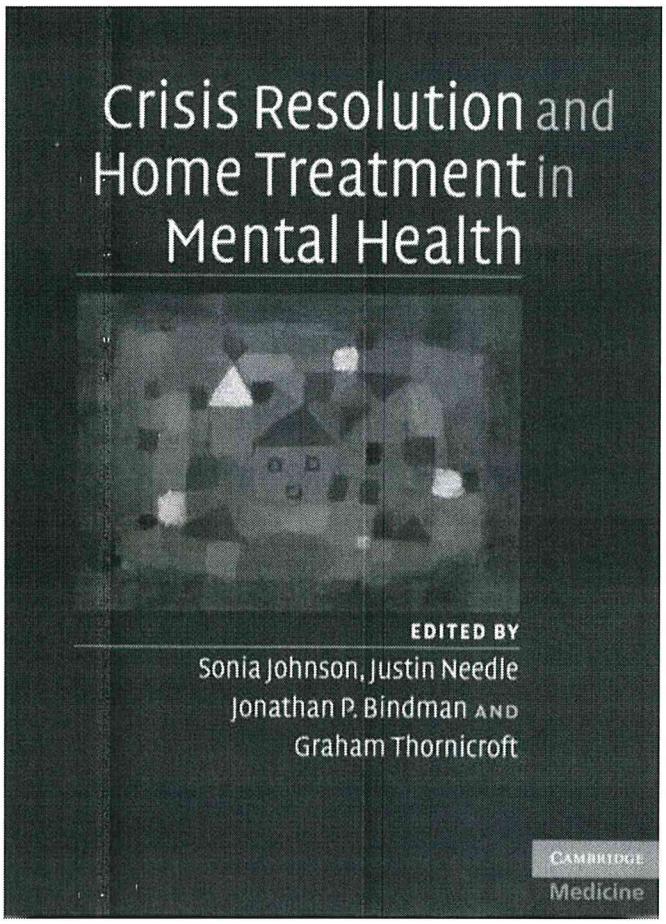
- EI to reduce the period of untreated psychosis in young people can prevent initial problems, improve long-term outcomes
- 50 EI teams will be established over next 3 years to provide treatment and active support in the community to these young people and their families
- By 2004 all young people who experience a first episode of psychosis will receive the early and intensive support they need

Assertive Outreach Services

- 50 teams will be established over next three years in addition to 170 teams which will be in place by 2001
- by 2003 all 20,000 people estimated to need assertive outreach will be receiving these services
- assertive outreach and intensive input 7 days a week needed to sustain engagement with services, and to protect patients and public

Crisis Resolution/Home Treatment Teams

- Crisis resolution teams respond quickly to people in crisis, providing assessment and treatment wherever they are
- 335 teams will be established over the next three years
- By 2004, all people in contact with specialist mental health services will be able to access crisis resolution services at any time
- The teams will treat around 100,000 people a year



Johnson S, Bindman J. & Thornicroft G. (eds) (2008)
Home Treatment Teams. Cambridge University Press, Cambridge.

Home Treatment Teams Save Beds

Background

2001-4 expansion in crisis resolution/home treatment teams in England

Aims

examine whether these teams associated with reductions in admissions

Method

observational study of routine data for 229 of the 303 local health areas

Results

- admissions fell throughout the period, particularly for younger adults
- CRT associated with greater reductions for women 35-64 years
- admissions fell by 10% more in the 34 areas with CRTs since 2001
- by 23% more in the 12 areas with CRTs on call around the clock
- reductions in bed use were smaller
- but assertive outreach teams not associated with reduced admissions

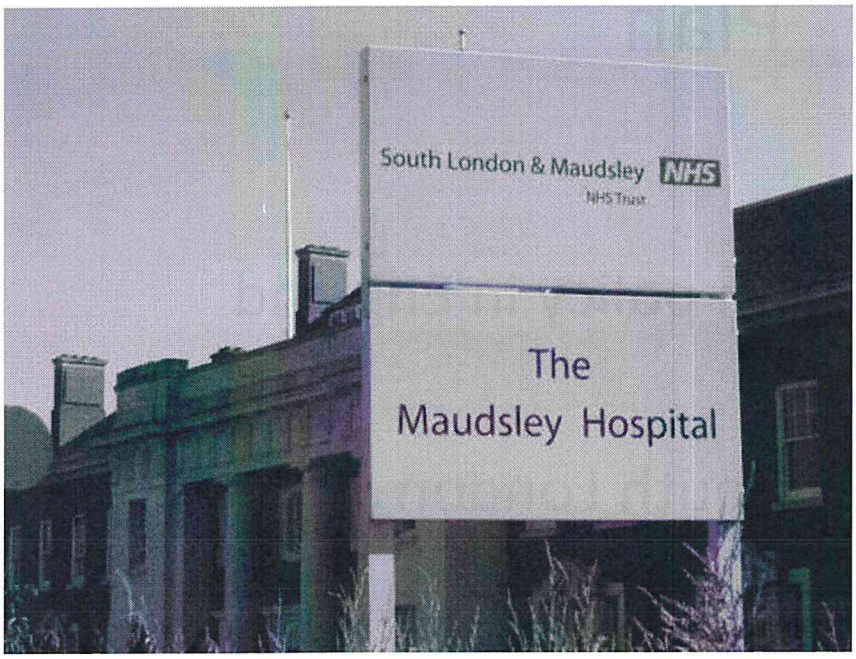
- Source: Glover G, et al. Crisis resolution/home treatment teams and psychiatric admission rates in England. Br J Psych. 2006; 189:441-445.

Plan

1. Recent mental health policy in England

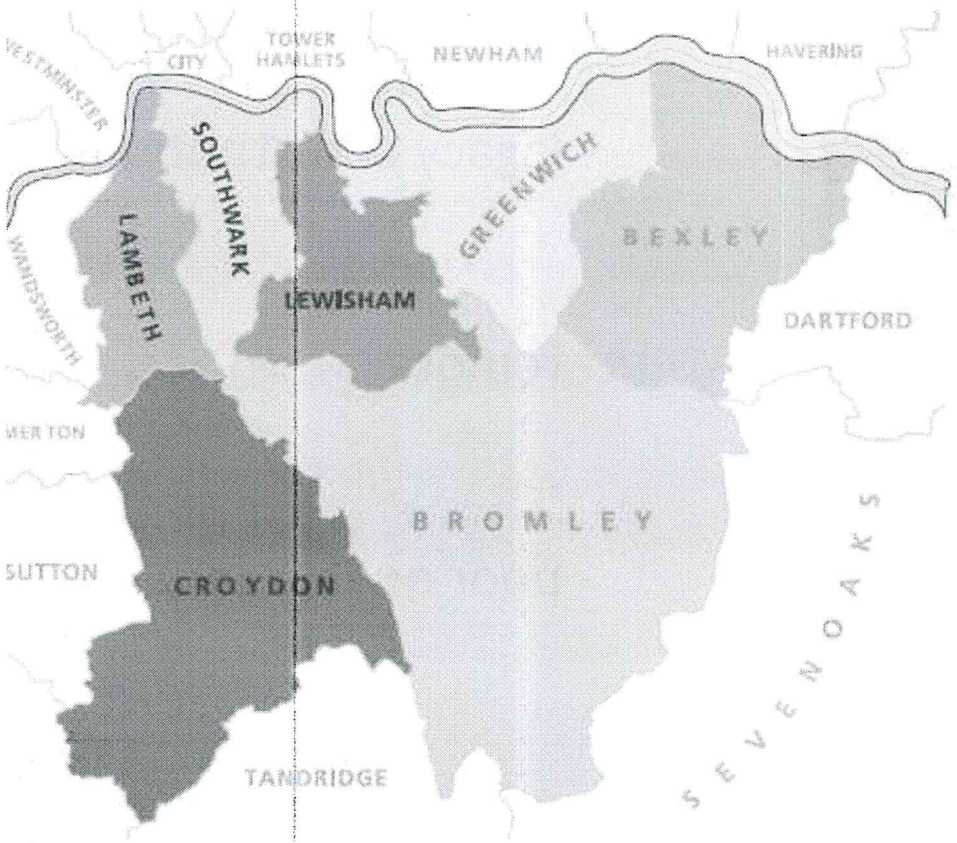
2. Implementation in South London

3. Lessons learned

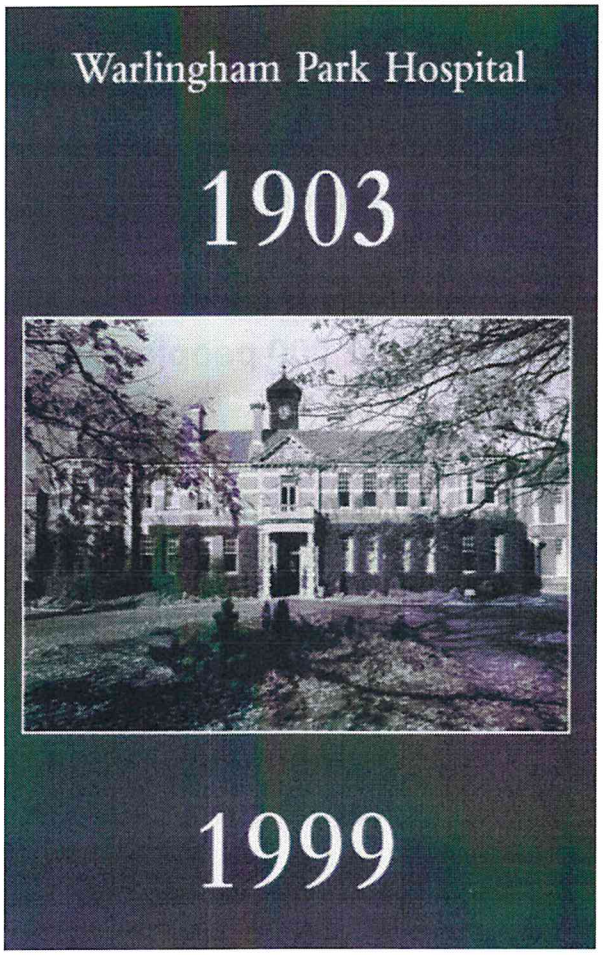


An example of local mental health service development: South London and Maudsley NHS Foundation Trust (SLaM)

SLaM in Practice



- **1.2m local population served**
- **local services to over 32,000 people a year**
- **national specialist services to 5500 patients a year**
- **community-orientated care from > 140 sites**

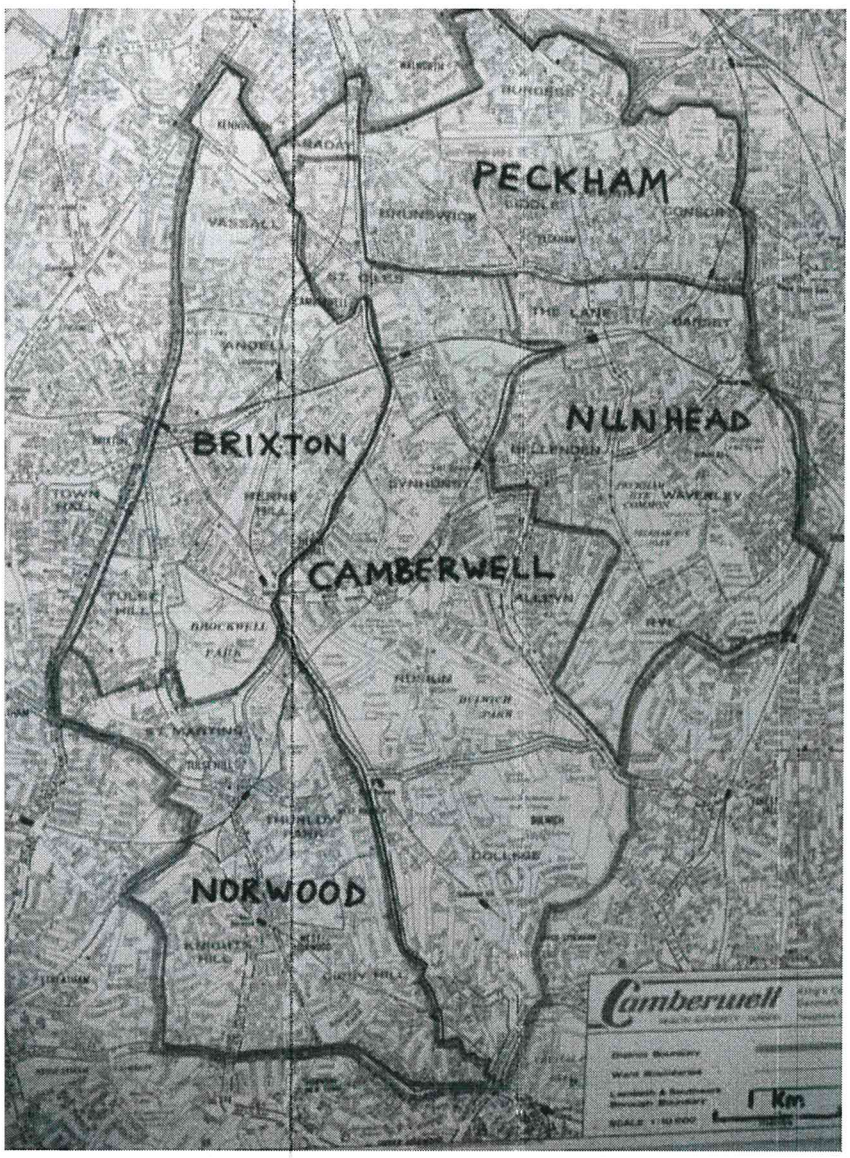


Background

- legacy of institutions

- remote

- poor quality care



1990

- planning starts for community teams

- staff redeployed from wards

- teams related to population needs

1991

Camberwell Interim Community Team

1992

Community Mental Health Centres established in Southwark and Lambeth

Guiding Principles

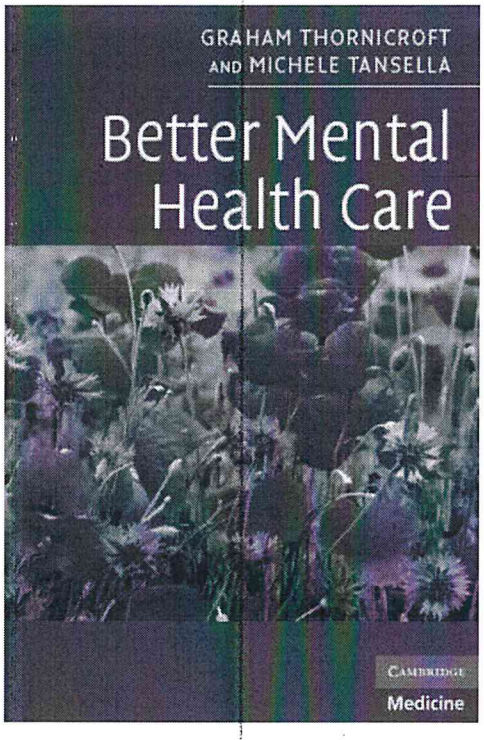
- services at (or close to) home
- interventions specfic to individual needs
- services reflect priorities of service users
- services co-ordinated between: 1° / 2° / 3° care
- generating evidence & translating into practice

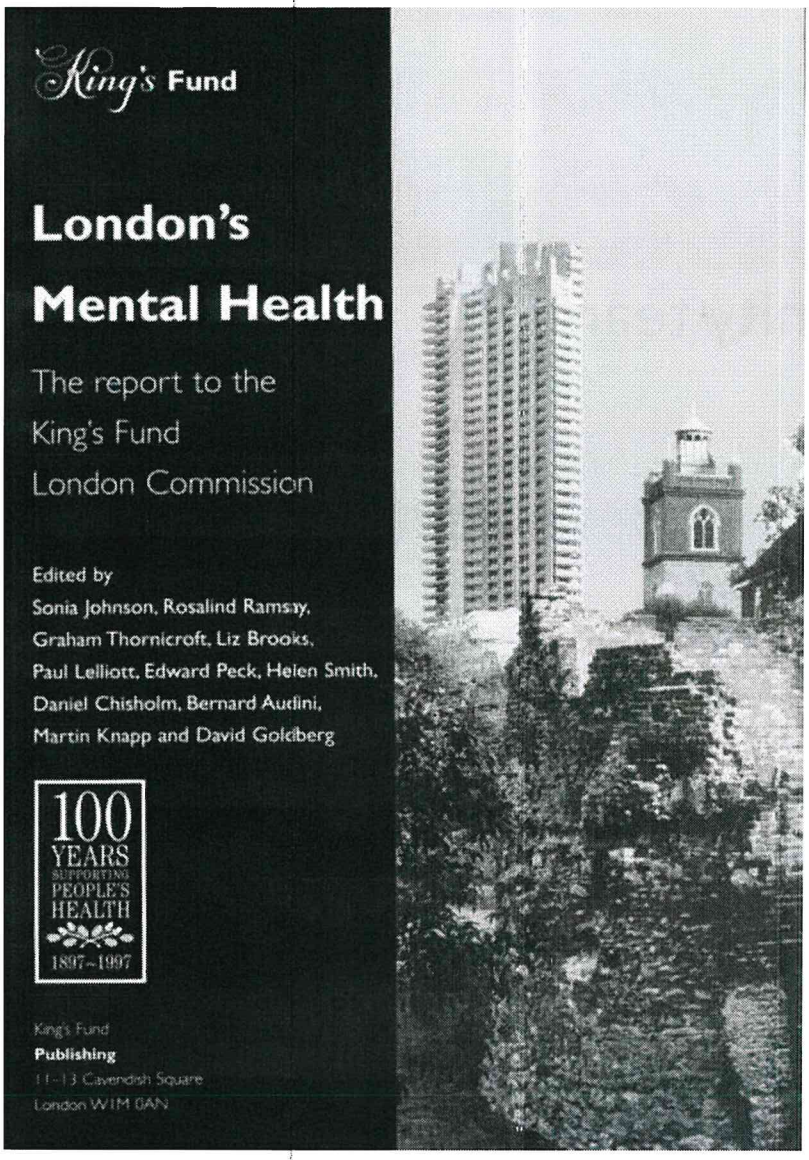
Working with local stakeholders

(Picture copyright Sheffield Star)

Service Model

- community mental health teams providing treatment at home & in clinics
- day care
- residential care
- as few beds as possible
- specialist clinics in primary care





1996

King's Fund Report

Needs assessment quantifies systemic shortfalls in care

template for service transformation

1998: Evaluation

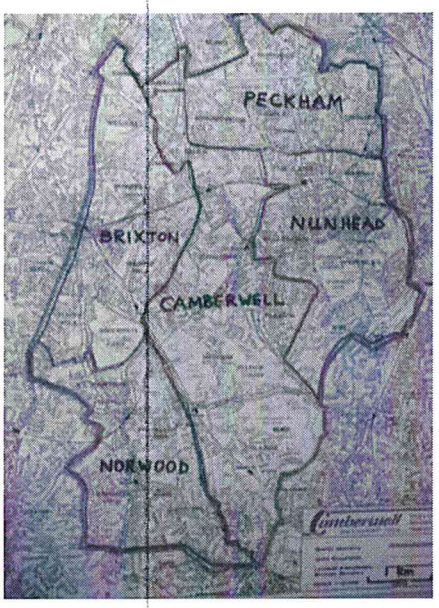
- benefits from community teams

– more met needs

– better quality of life

– larger social networks

– more cost effective



BRITISH JOURNAL OF PSYCHIATRY (1998), 173, 423–427

PRiSM

From efficacy to effectiveness in community mental health services

PRiSM Psychosis Study 10

GRAHAM THORNICROFT, TIL WYKES, FRANK HOLLOWAY, SONIA JOHNSON and GEORGE SZMUKLER

1999

change from 4 to 140 services sites to serve catchment population of 1.2m

2000: Croydon Women's Service, South London: an alternative to hospital admission

Admission to Women's Crisis Houses or to Psychiatric Wards: Women's Pathways to Admission

Louise M. Howard, Ph.D., M.R.C.Psych.
Elena Rigon, M.D.
Laura Cole, B.Sc., M.Sc.
Caroline Lawlor, B.Sc., M.Sc.
Sonia Johnson, Ph.D., M.R.C.Psych.

(Psychiatric Services 59:1443–1449, 2008)

- acceptable to women residents
- accelerated referral pathways
- less casualty use

Lambeth Early Intervention Community Team

- opened 2000: innovative early episode service
- provides 6 day a week intensive & assertive follow-up, outreach and crisis intervention of clients
- 501 clients followed up to date by LEO crisis community team

Cite this article as: BMJ, doi:10.1136/bmj.38246.594873.7C (published 14 October 2004)

Papers

The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis

Tom K J Craig, Philippa Garety, Paddy Power, Nikola Rahaman, Susannah Colbert, Miriam Fornells-Ambrojo, Graham Dunn

- fewer relapses
- fewer loss to contact to care

SURE: Service User Research Enterprise Consumer Research Team, Institute of Psychiatry, KCL

Patients' perspectives on electroconvulsive therapy: systematic review

Diana Rose, Til Wykes, Morven Leese, Jonathan Bindman, Pete Fleischmann

ELPS

This is an abridged version; the full version is on bmj.com

Editorial by Geddes and Carney

Service User Research Enterprise, PO34, Institute of Psychiatry, De Crespigny Park, London SE5 8AF
Diana Rose *senior researcher*
Pete Fleischmann *researcher*
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Til Wykes *professor*
Health Services Research Department, Institute of Psychiatry
Morven Leese *statistician*
Jonathan Bindman *senior lecturer*
Correspondence to: D Rose
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BMJ 2003;326:1363–5

Abstract

Objective To ascertain patients' views on the benefits of and possible memory loss from electroconvulsive therapy.
Design Descriptive systematic review.
Data sources Psychinfo, Medline, Web of Science, and Social Science Citation Index databases, and bibliographies.
Study selection Articles with patients' views after treatment with electroconvulsive therapy.
Data extraction 26 studies carried out by clinicians and nine reports of work undertaken by patients or with the collaboration of patients were identified; 16 studies investigated the perceived benefit of electroconvulsive therapy and seven met criteria for investigating memory loss.
Data synthesis The studies showed heterogeneity. The methods used were associated with levels of perceived benefit. At least one third of patients reported persistent memory loss.
Conclusions The current statement for patients from the Royal College of Psychiatrists that over 80% of patients are satisfied with electroconvulsive therapy and that memory loss is not clinically important is unfounded.

Methods

We searched relevant databases for papers and reports of patients' views on treatment with electroconvulsive therapy (see bmj.com for search terms). Articles were excluded that concerned lay or professional opinion, children or adolescents, or where not all the patients had received treatment.

Of the 27 papers identified, 26 were authored by academics or researchers and conducted in psychiatric facilities. Nine reports were written either by patients or in collaboration with them. The work of Communicate, the user group at the Maudsley hospital, is awaiting publication, but we had access to its raw data.

We calculated the proportion of patients with positive responses to questions on effectiveness of treatment and the 95% confidence intervals. Positive responses were defined as an affirmative response to the statements "electroconvulsive therapy is helpful" or "I would have electroconvulsive therapy again." A Forrest plot was produced on the raw (proportion) scale as to whether electroconvulsive therapy was considered helpful.

The research studies were rated on four methodological variables. Firstly, we considered the interval between treatment and interview, because the benefits of treatment may be short lived and side effects only

Rose D et al, BMJ (21.6.03) 326, 1363-5

Diverse Local Population

Southwark 2001 census population 244,866

- White 63%
- Other 9%
- Black 28%
  - African 57%
  - Afro-Caribbean 29%
  - Other 14%

Cares of Life Project (COLP) in Peckham

- outreach services to black community
- for people with anxiety/depression
- community health workers are link between volunteers and statutory services
- contacts in faith communities and barbershops

Nurse volunteers measuring blood pressure inside CoLP bus

Dr Dele Olajide of Cares of Life Project at Redeemed Church of Christ

Evaluation (RCT)

- acceptable
- culturally approp.
- faster resolution of anxiety/depression
- no greater cost
- In press: Journal of Affective Disorders

Plan

1. Recent mental health policy in England

2. Implementation in South London

3. Lessons learned

Service Improvement in the Real World

1. Anxiety from Uncertainty and Threats

- What can be guaranteed eg no redundancies
- Maximise staff choice eg continue in hospital
- Statements from managers on risk taking
- Make interim / changeable arrangements
- Allow/encourage mistakes and learn/adapt

2. Lack of Structure in Community Services

- Compensate with extra / excess structure
- Regular meetings for clinical purposes
- Ongoing training sessions
- Staff only team support groups
- Agreed procedures eg assessment/referral
- Common operational policies

Daily Multi-disciplinary Team Meeting

3. How to Initiate

- Visit other sites
- Get their documents and rotas and budgets
- Appoint enthusiastic project managers
- Project management: who does what, when
- Performance manage allocated tasks
- Plan exit strategy from the start

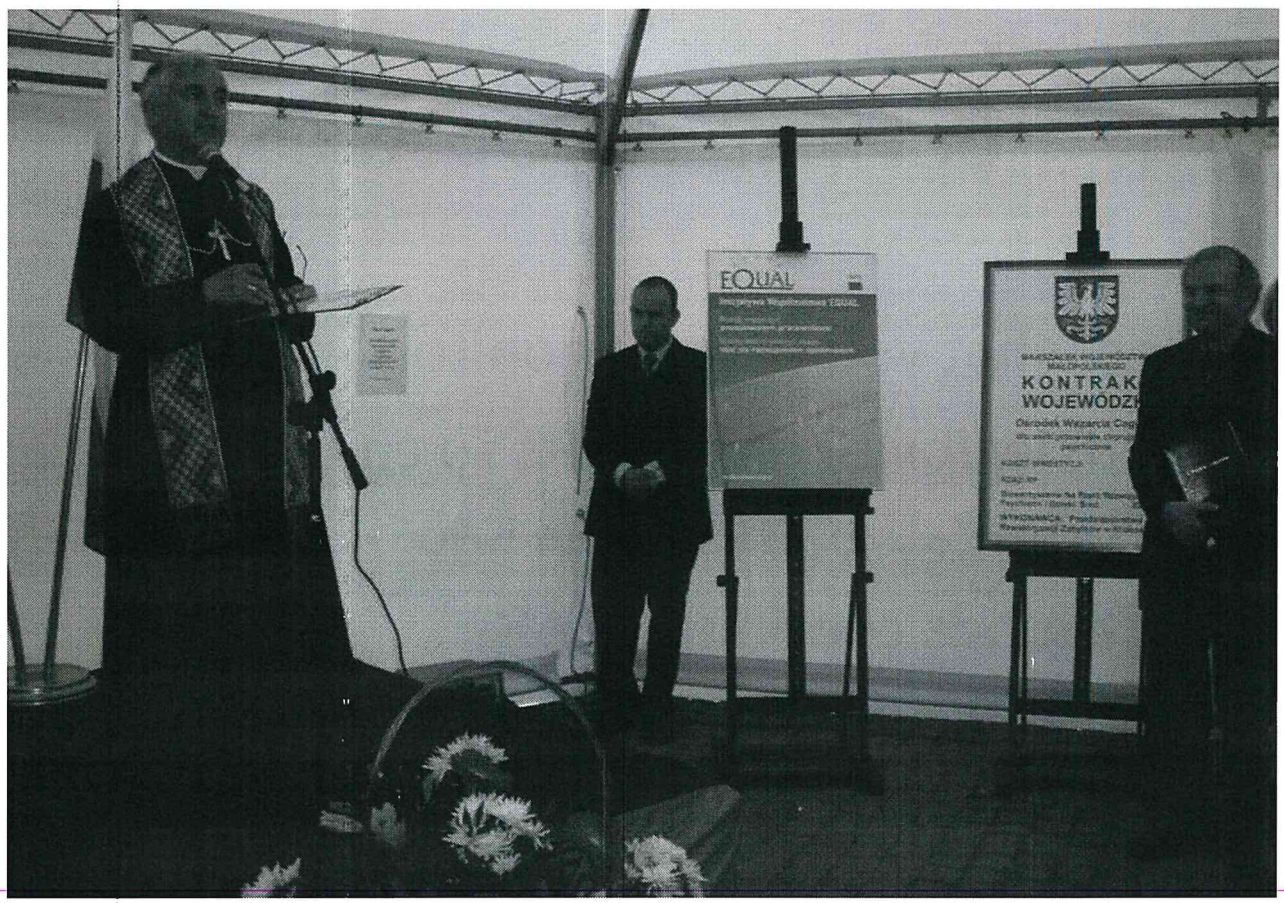
4. Initial Opposition within the Mental Health System

- Widespread consultation
- Cross-sectoral consortium
- Volunteer to write plans and proposals
- Allow valued hospital roles in future
- Where there is retirement there is hope...
- Create sense of the inevitability of new system
- Link to external legitimation eg WHO

Community Mental Health centre: South London

5. Opposition from Neighbourhood

- Options: tell nothing or tell everything!
- My view: maximum discussion with neighbours and negotiate with them
- Expect that their views/demand will be reasonable…from their point of view
- Allow time for community members to admit that they know mentally ill people
- Set up local advisory group with neighbours



Opening of Hotel Staffed by Service Users, Krakow, Poland

6. Financial Obstacles

- Keep what you have – monitor finances!
- Need flexibility of budgets to change services
- Share budgets if this is an advantage Advocate for extra funds continuously
- Be friends with insurance / finance ministry
- Stress modern, cost-effective, evidence-based

7. System Rigidity

- Develop mechanisms for flexibility
- Secondments/visits to other services
- Shadowing/following staff in other sites
- Joint appointment posts in 2 organisations
- Inter-agency purchasing or providing groups
- Value people who have 2 types of training
- Institutionalise new training curricula

Community Mental Health Centre in South London
with Specialist Mother & Baby Clinics

8. Boundaries and Barriers

- Senior managers need whole system perspective
- Allow service components which help overall system
- Do not allow components to define their own inclusion/exclusion criteria- they want a comfortable life for staff!
- Keep looking for boundary dysfunction and fix
- Regular meetings and repeat why change the service

9. Maintain Morale

- Evidence is that community and hospital staff moral will be equally low!
- But at times of transition even worse…
- Take every opportunity to share and communicate successes
- Also have a party at any excuse!

10. What is the Right Answer?

- There is no right answer
- Services in other areas may be irrelevant
- New services will make mistakes
- Allow reasonable risks
- Monitor and learn from successes / mistakes
- Guide: service user & family member views

Overall lessons ...

- for lasting improvements, service changes may need to be developed slowly and carefully
- at initiation stage – need charismatic leaders
- at consolidation phase – need boring leaders
- during changes be very alert for budget cuts
- deinstitutionalise asylums
- reinstitutionalise training curricula
- most importantly: listen to users and to family members

References & Resources

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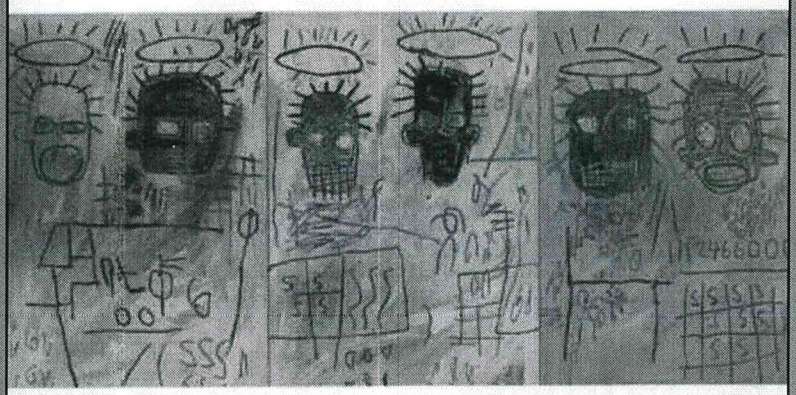
GRAHAM THORNICROFT



SHUNNED

discrimination against people with mental illness

WINNER – MENTAL HEALTH CATEGORY
BMA MEDICAL BOOK AWARDS 2007

OXFORD

What is Stigma?

- Problem of knowledge = Ignorance
- Problem of attitudes = Prejudice
- Problem of behaviour = Discrimination

Reaction by neighbours to community mental health centre in Yorkshire

Physical health care

- people with mental health problems more likely to have: eg smoking, heart disease, diabetes and stroke

- '*diagnostic overshadowing*' ie reports of physical ill health are viewed as part of the mental health problem & so are under-treated

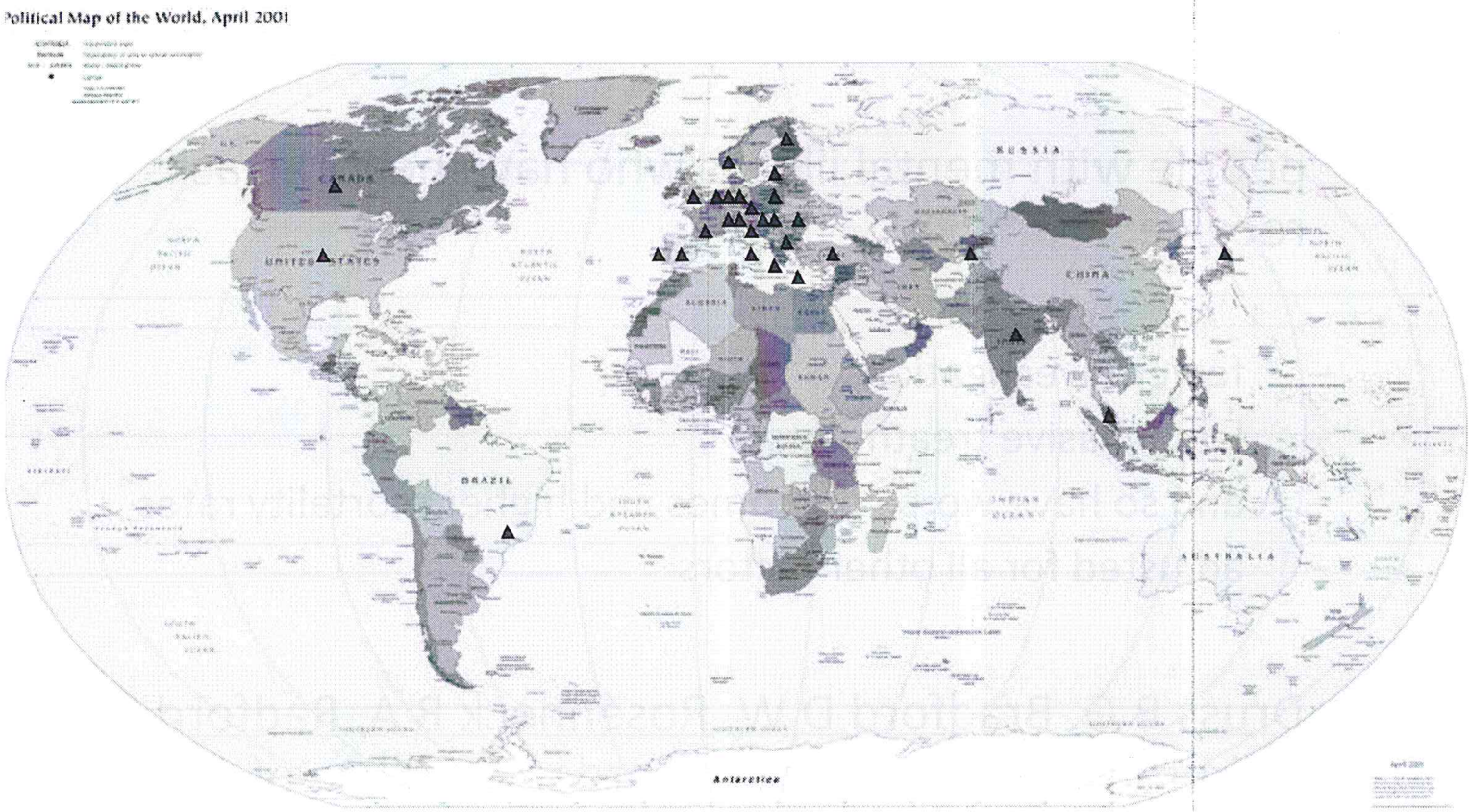
- Jones S, Howard L, Thornicroft G. (2008) 'Diagnostic overshadowing': worse physical health care for people with mental illness. Acta Psychiatria Scandanavica, 118, 169-71

Healthcare and discrimination

- people with mental illness who have heart attacks receive:
  - fewer investigations
  - less invasive treatments
  - and so have worse outcomes and higher mortality rates
  - adjusted for all other factors

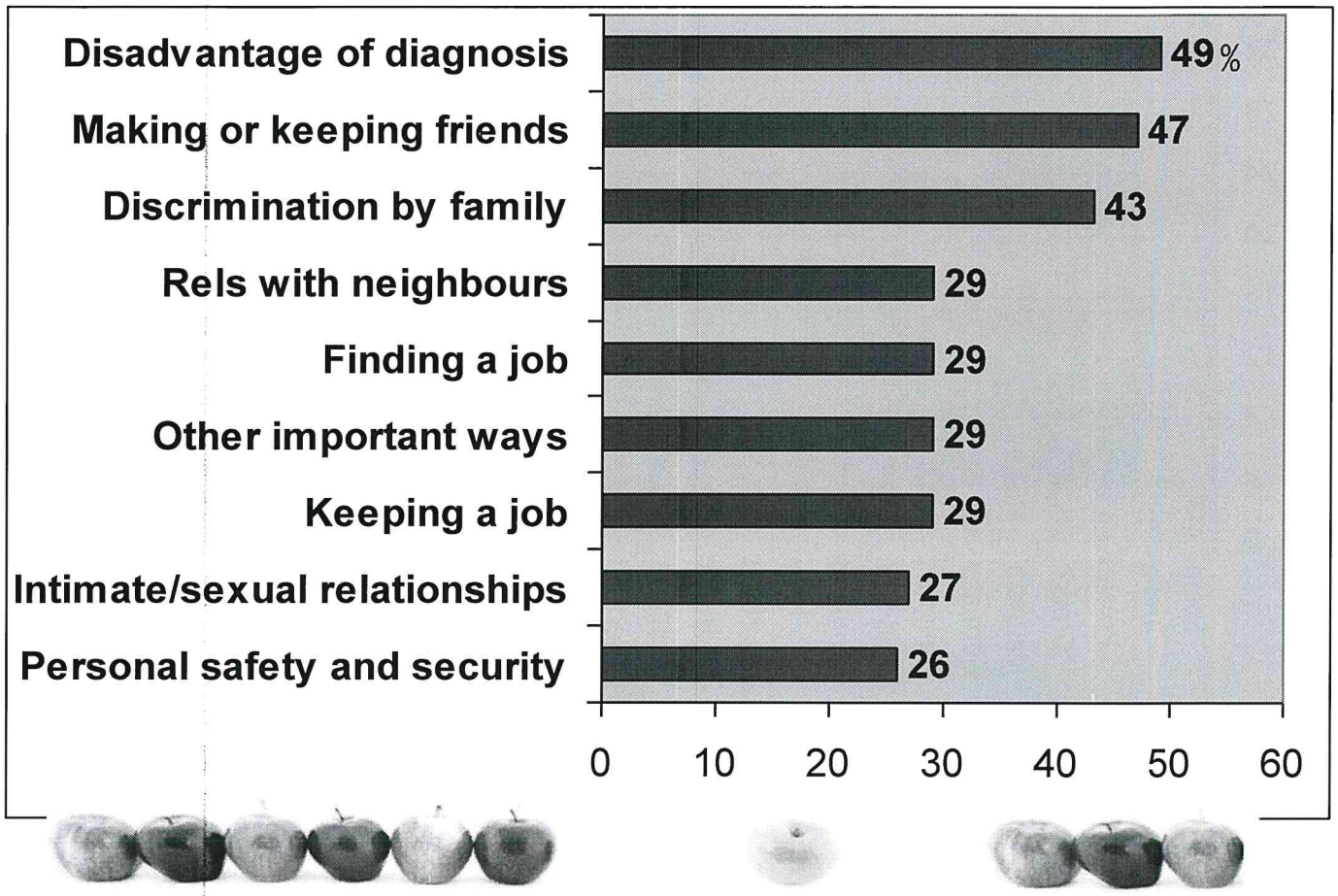
- Druss B G, Bradford D W, Rosenheck R A, Radford M J, Krumholz H M. Mental disorders and use of cardiovascular procedures after myocardial infarction. JAMA 2000; (283): 506-511

INDIGO Schizophrenia Study Sites

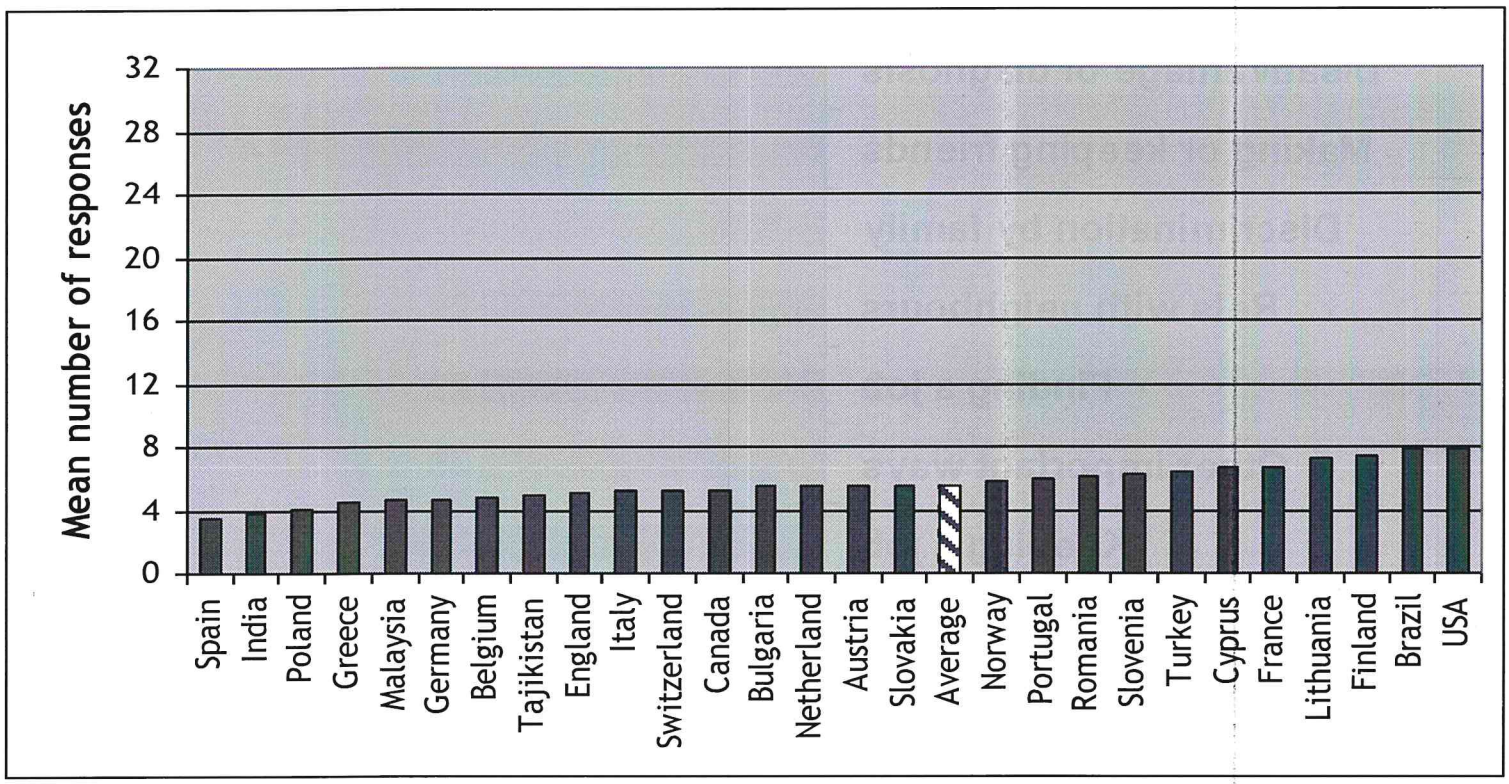


732 people interviewed in 27 countries using Discrimination and Stigma Scale (DISC)

Negative Experienced Discrimination 1



Negative Experienced Discrimination 2

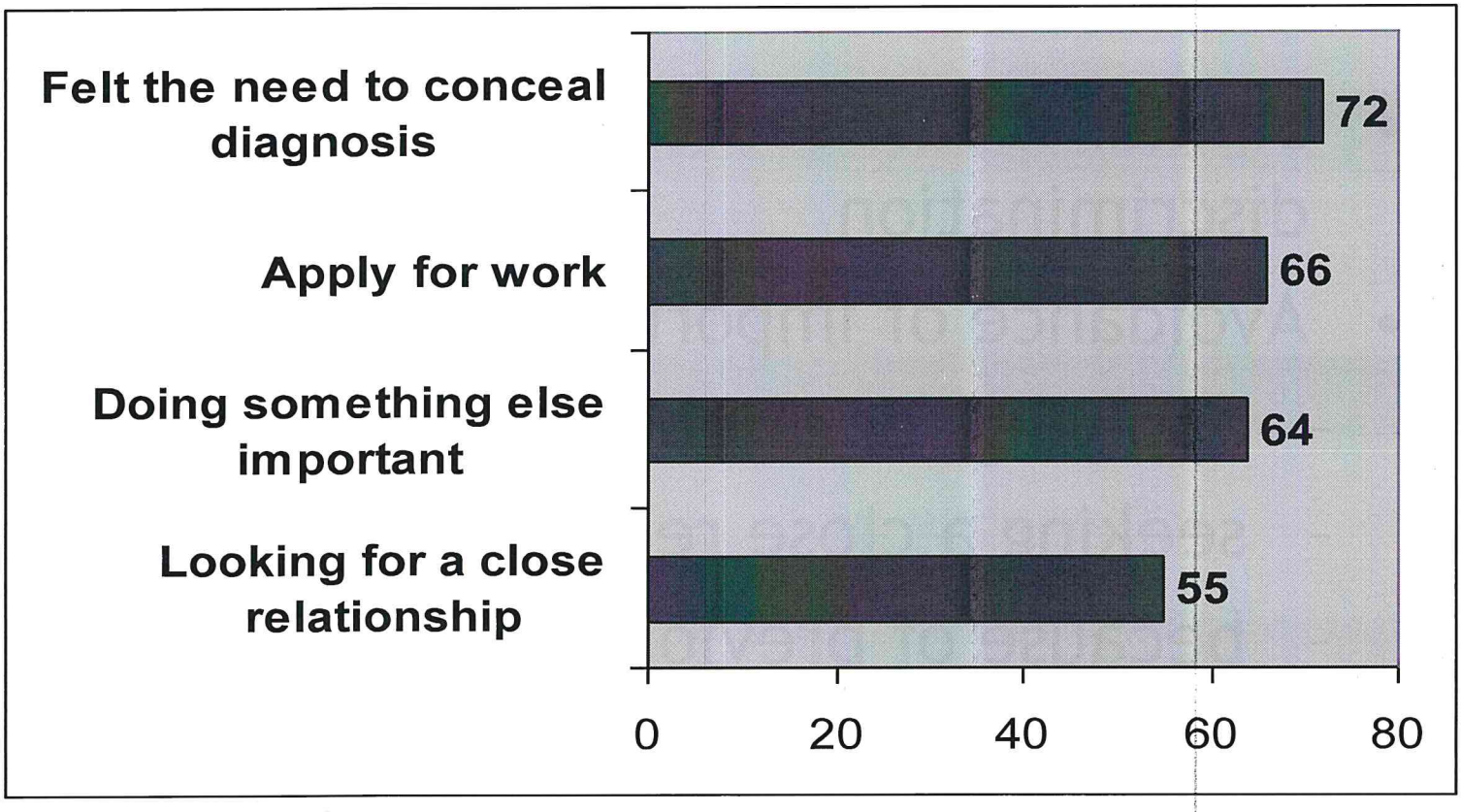


ICC = 0.044 (95% CI: 0.001-0.086)

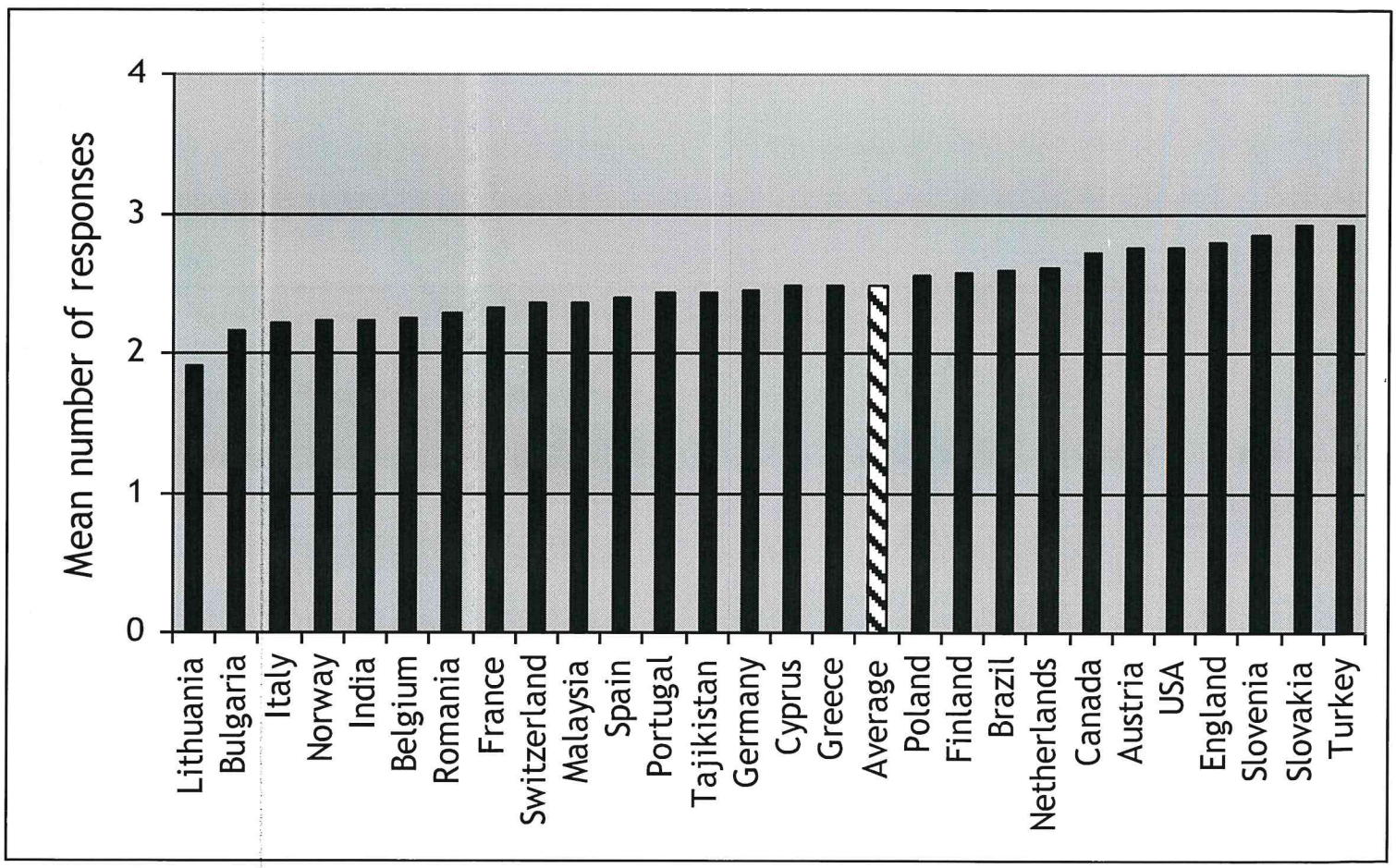
Anticipated Discrimination

- Similar ideas: self-stigma, self-discrimination
- Avoidance of important actions: eg
  - applying for a job
  - seeking a close relationship
  - because of previous failure or
  - in anticipation of failure

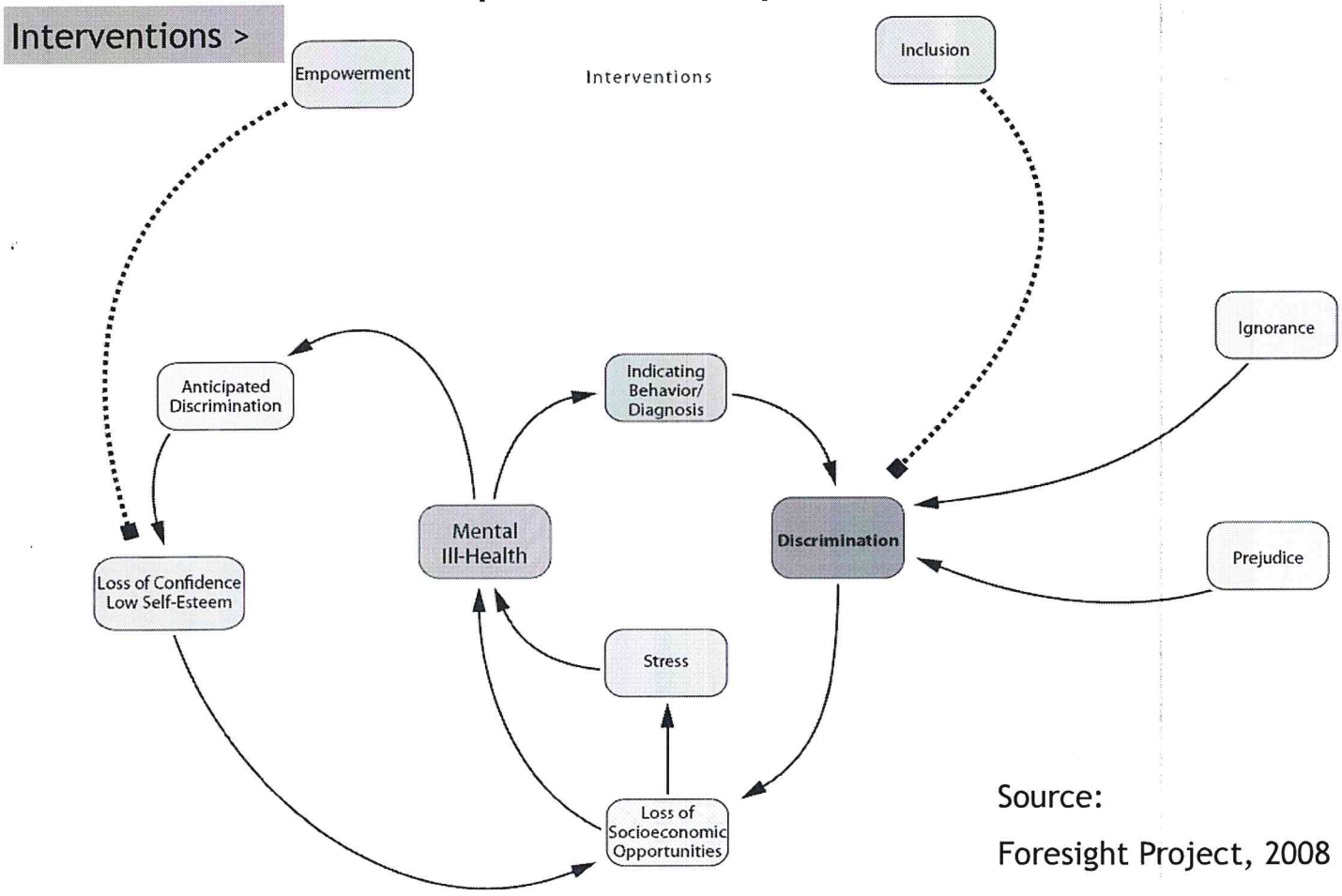
Anticipated Discrimination



Anticipated Discrimination by Country (range 0-4)



Schema for Anticipated & Experienced Discrimination



Source:

Foresight Project, 2008

Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey

*Graham Thornicroft, Elaine Brohan, Diana Rose, Norman Sartorius, Morven Leese, for the INDIGO Study Group**

Lancet 2009; 373: 408–15
Published Online January 21, 2009
DOI:10.1016/S0140-6736(08)61817-6

See Comment page 362

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Summary

Background Many people with schizophrenia experience stigma caused by other people's knowledge, attitudes, and behaviour; this can lead to impoverishment, social marginalisation, and low quality of life. We aimed to describe the nature, direction, and severity of anticipated and experienced discrimination reported by people with schizophrenia.

Methods We did a cross-sectional survey in 27 countries, in centres affiliated to the INDIGO Research Network, by use of face-to-face interviews with 732 participants with schizophrenia. Discrimination was measured with the newly validated discrimination and stigma scale (DISC), which produces three subscores: positive experienced discrimination; negative experienced discrimination; and anticipated discrimination.

Findings Negative discrimination was experienced by 344 (47%) of 729 participants in making or keeping friends, by 315 (43%) of 728 from family members, by 209 (29%) of 724 in finding a job, 215 (29%) of 730 in keeping a job, and by 196 (27%) of 724 in intimate or sexual relationships. Positive experienced discrimination was rare. Anticipated discrimination affected 469 (64%) in applying for work, training, or education and 402 (55%) looking for a close relationship; 526 (72%) felt the need to conceal their diagnosis. Over a third of participants anticipated discrimination for job seeking and close personal relationships when no discrimination was experienced.

Interpretation Rates of both anticipated and experienced discrimination are consistently high across countries among people with mental illness. Measures such as disability discrimination laws might, therefore, not be effective without interventions to improve self-esteem of people with mental illness.

Acknowledgments

This study is related to a National Institute for Health Research (NIHR) Applied Programme grant awarded to the South London and Maudsley NHS Foundation Trust (EB, DR, GT), and to the NIHR Specialist Mental Health Biomedical Research Centre at the Institute of Psychiatry, King's College London and the South London and Maudsley NHS Foundation Trust (DR, GT).

Local level interventions

Social contact theory

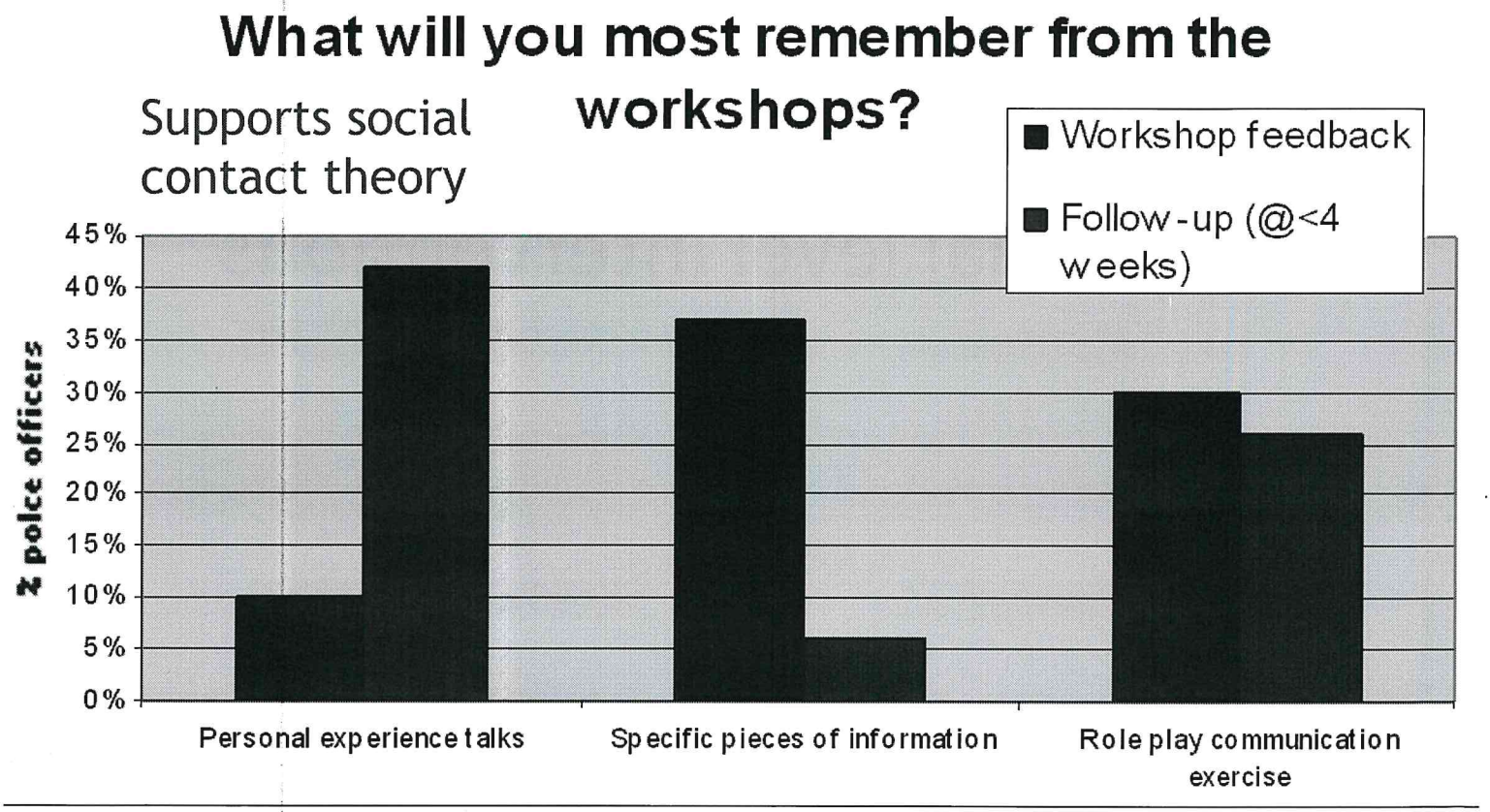
- Bogardus 1924
- direct, personal contact with individual(s) of stigmatised group
- equal status (eg co-facilitator)

Target Groups

- Police officers ✓
- Young people ✓
- Medical students ✓
- Trainee psychiatrists
- Student teachers
- Nurse students

1. Pinfold V. et al (2003). Reducing psychiatric stigma and discrimination: Evaluating an educational intervention with the police force in England. Social Psychiatry & Psychiatric Epidemiology, 38, 337-344.
2. Pinfold V. et al (2003). Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools. British Journal of Psychiatry, 182, 342-346.
3. Kassam A, Thornicroft G et al (2010) Mental illness: clinicians' attitudes scale. Acta Psychiatria Scandanavica

Feedback from Police



Pinfold V., Thornicroft G., Huxley, P., & Farmer, P. (2005). Active ingredients in anti-stigma programmes in mental health. Int. Review of Psychiatry, 17, 123-132

National level interventions

National campaigns

- Australia
- New Zealand
- Scotland
- England
- Canada
- Sweden
- Denmark

John Kirwan: New Zealand rugby legend

> featured in the National Depression Initiative
> national survey showed 78% recalled the advertisements
> of these 98% were positive about them
> personal honesty & openness key factors in campaign success e.g.

time to change

let's end mental health discrimination

mind
For better mental health

rethink

Evaluation partner
Institute of Psychiatry
KING'S College LONDON
University of London

LOTTERY FUNDED

COMIC RELIEF

Aftenposten
NEWS FROM NORWAY
First published: 20 Sep 2006, 10:54

Psychiatric problems plague one of four Norwegians

Norway seems to be offering living proof that money can't buy happiness. The country often is referred to as among the world's wealthiest, and the best place to live, but a new study indicates that 25 percent of the adult population falls mentally ill every year.

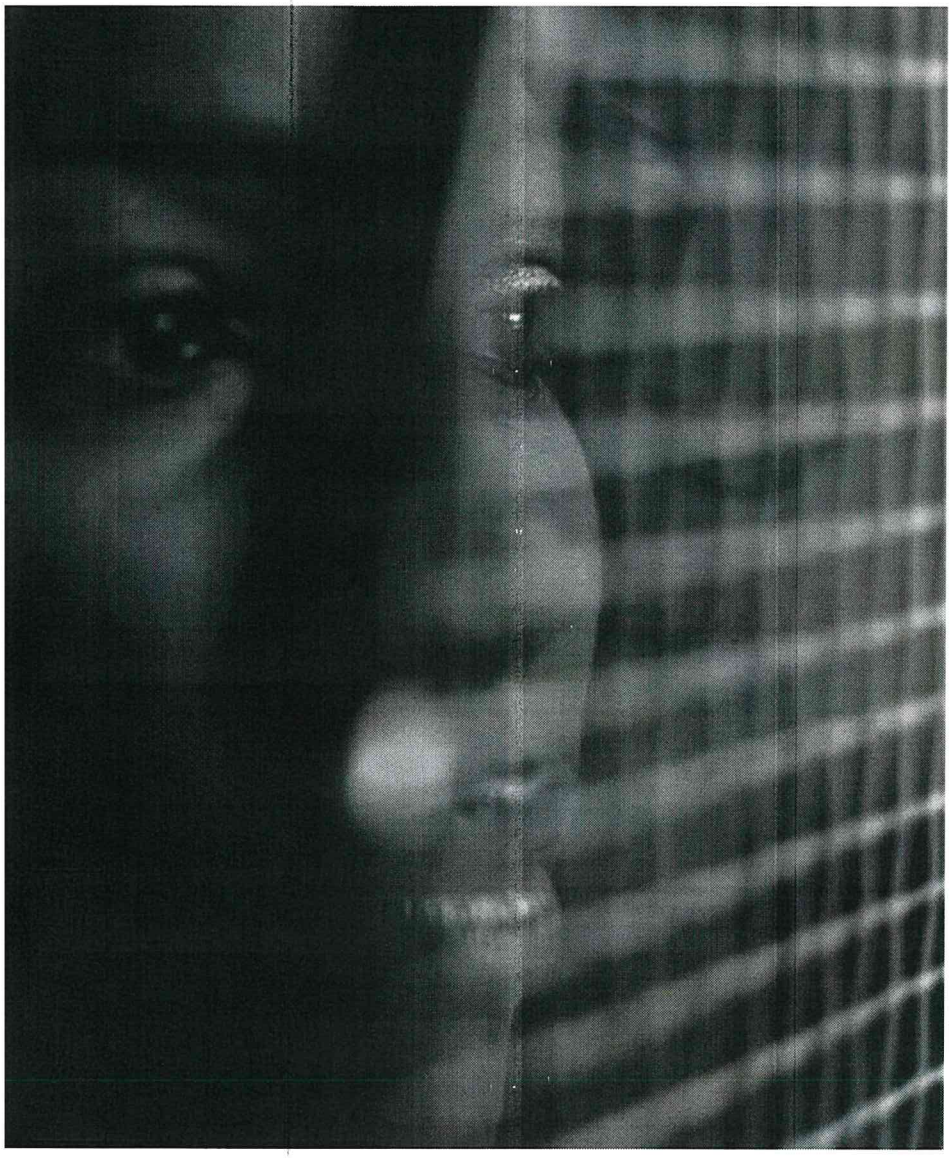
The study, conducted by the Psychiatric Institute at the University of Oslo, is based on data collected by health authorities in eastern Norway.

The amount of people seeking psychiatric treatment amounts to 25 percent of all adult Norwegians. Another 450,000 Norwegians are believed to suffer psychiatric problems, but don't bother visiting a doctor.

Norwegian Prime Minister Kjell Magne Bondevik has been among those seeking psychiatric help, after being diagnosed with a "depressive reaction" during his first term in the late 1990s. He and other government officials have been calling for more openness and funding for mental health programs.

PHOTO: JON HAUGE

Anxiety and depression



'I didnt leave my house for weeks. I didn't talk to anyone...you don't want to accept help. It's not easy

My drive, my sense of mission and purpose, my desire to be the best in the world.. all these things had fallen away.

I didn't know it at the time but I was slipping into a depression.'

Guardian Weekend 29.08.09

time to change

let's end mental health discrimination

Summary of first year follow-up results

After 1st year, consistent pattern of moderate & positive changes: knowledge, attitudes and (sometimes) behaviour:

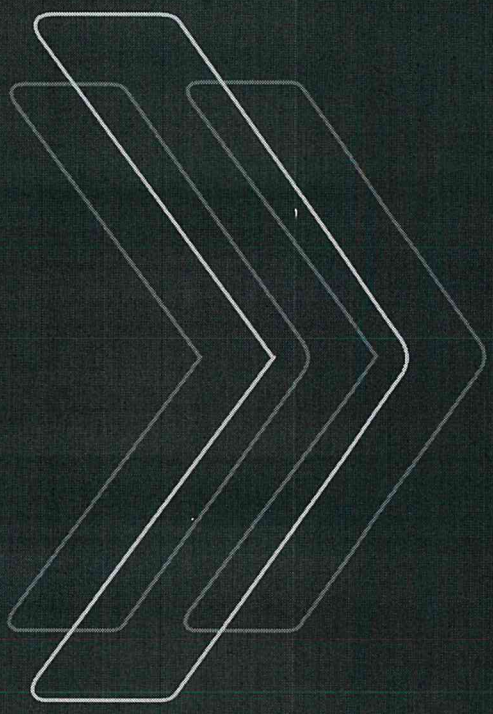
- General public
- People with severe mental health problems
- Medical and teaching students
- Press cuttings analysis
- Best predictor of favourable views is direct social contact
- Celebrity endorsement may be important

The King's Fund

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Mental health and new models of care

Lessons from the vanguards



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Holly Taggart

Anna Charles

May 2017

Contents

Key messages

- The new models of care introduced by the *NHS five year forward view* (Forward View) create an important opportunity to deliver whole-person care that responds to mental health, physical health and social needs together.
- Developing more integrated approaches to mental health should be a key priority given the close links between mental health and physical health outcomes, and the impact these have on the quality and costs of care. It is now well established that when the mental health needs of people with physical health conditions are not adequately addressed, this increases costs and undermines patient outcomes.
- Many of the vanguard sites have included some mental health components in their care models, with several reporting promising early results and some emerging lessons that other areas may benefit from. For example, in areas that have incorporated mental health expertise into integrated care teams, team members report that the contribution of their mental health colleagues has been highly valuable in improving the support delivered to people with complex and ongoing care needs.
- Despite these positive steps, our overall assessment is that the full opportunities to improve care through integrated approaches to mental health have not been realised. The level of priority given to mental health in the development of new models of care has not always been sufficiently high. This is not consistent with the spirit of the commitment in *The five year forward view for mental health* (Forward View for Mental Health), which identified integrating physical and mental health as one of its three key priorities.
- The critical measure of success is that when taken together, the work done in the vanguard sites allows adequate testing of hypotheses about the potential impact of integrating mental health within new models of care. Our concern is that the service changes brought about to date may not be sufficiently ambitious to allow for this.

- In developing the multispecialty community provider (MCP) and primary and acute care system (PACS) models further, there is significant scope to make more progress in the following areas:
  - ensuring that integrated care teams designed to support people with complex and ongoing care needs can make full use of mental health expertise, with mental health capacity and capabilities sufficient to meet the needs that exist
  - making new forms of mental health support a core component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice, and to meet the physical health care needs of people with long-term mental health problems
  - further strengthening mental health components of urgent and emergency care pathways in accident and emergency (A&E) departments and elsewhere
  - making public mental health and wellbeing central to population health management approaches, including through a focus on perinatal mental health, children and young people, where some of the greatest opportunities for prevention lie.

- As new models of care are developed in other areas beyond the vanguard sites, two things will need to be done to ensure that the opportunities relating to mental health are not missed. First, testing the mental health components of existing vanguard sites must be a central part of local and national evaluations of new care models. Second, other local areas rolling out MCPs, PACS and related care models should aim to go further than the vanguard sites in the four areas listed above.

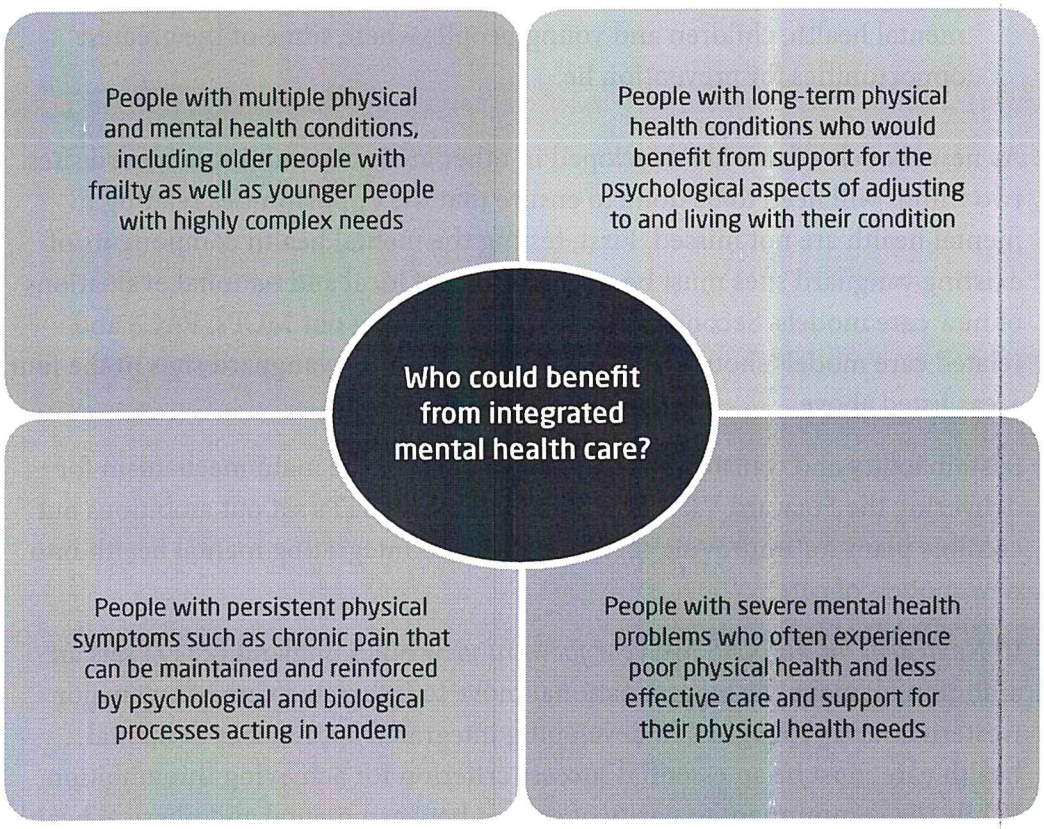
- Sustainability and transformation plans (STPs) are the main mechanism for delivering the Forward View. It is essential that all STPs set out ambitious but credible plans for improving mental health and integrating mental health into new models of care.

- In *Next steps on the NHS five year forward view* NHS England (2017) sets an ambition to 'make the biggest national move to integrated care of any major western country'. Progress in developing integrated approaches to mental health care must be an essential success criterion for achieving this ambition. While the commitment to parity of esteem between mental and physical health is hugely significant, it is time to turn the rhetoric into reality.

1 Introduction

Mental health care is often disconnected from the wider health and social care system – institutionally, professionally, clinically and culturally. Artificial boundaries between services mean that many people do not receive co-ordinated support for their physical health, mental health and wider social needs, and instead receive fragmented care that treats different aspects of their health and wellbeing in isolation. Figure 1 illustrates some of the groups of people who frequently suffer as a result.

Figure 1 Potential beneficiaries of integrated approaches to mental health



Previous research has argued that integrated care initiatives in England and elsewhere have not yet focused enough on the opportunities to overcome these boundaries and develop more integrated approaches towards mental health (Naylor *et al* 2016). This is despite evidence indicating that there is significant scope both to improve the quality of care and to use available resources more efficiently by doing so. For example, it is now well established that mental health problems are very common among people with long-term physical health conditions, and that when these mental health needs are not adequately addressed, the effect is often to drive up the costs of care and undermine outcomes (Naylor *et al* 2012). In the case of people with severe mental illnesses, poor physical health and barriers to accessing physical health care have led to a situation where they are likely to die 10 to 20 years earlier (on average) than the wider population – one of the starkest health inequalities seen in the UK (Working Group for Improving the Physical Health of People with SMI 2016).

Figure 2 (p 7) provides a summary of key facts and figures illustrating the case for change in terms of patient outcomes, system pressures and the financial costs of the current situation, while Figure 3 (p 8) illustrates some of the mechanisms through which physical and mental health interact.

Figure 2 **The case for developing integrated approaches to mental health: summary of key facts and figures**

Patient outcomes

- Poor mental health is a major risk factor for a wide range of physical health conditions, and can also be a consequence of physical illness. Around 30 per cent of people with one or more long-term physical health conditions also have a mental health problem; this figure is higher among people with multiple conditions (Naylor *et al* 2012).
- Depression and anxiety disorders lead to significantly poorer outcomes among people with diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and other long-term conditions (Jünger *et al* 2005; Katon *et al* 2005; Blumenthal *et al* 2003; Lespérance *et al* 2002).
- Compared to the general population, people with severe mental illnesses are 4.7 times more likely to die from liver disease, 4.6 times more likely to die from respiratory disease, 3.2 times more likely to die from cardiovascular disease, 1.7 times more likely to die from cancer, and overall die 10–20 years earlier on average (Taggart and Bailey 2015; Brown *et al* 2010).

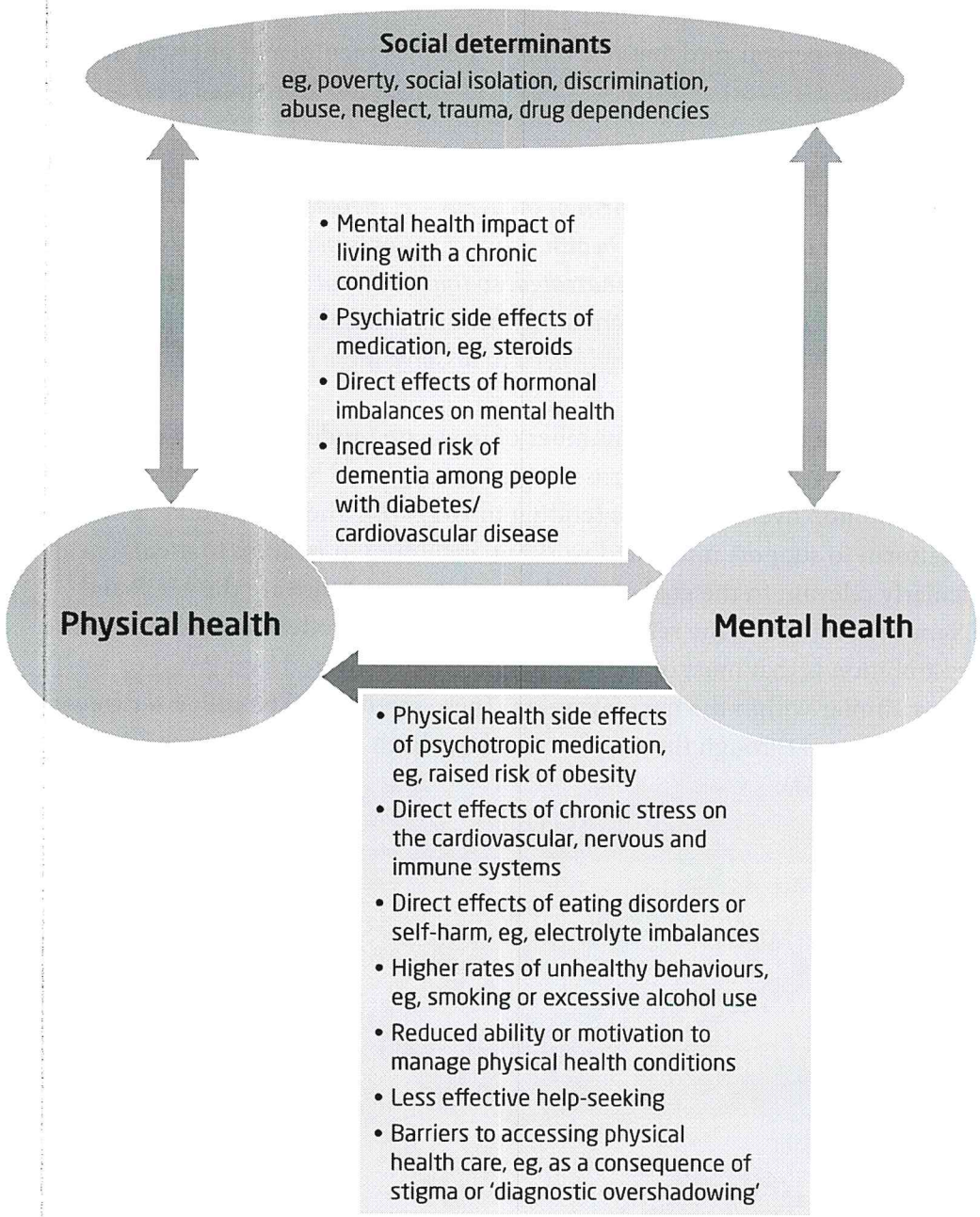
System pressures

- People with mental health problems use significantly more unplanned hospital care for physical health needs than the general population, including 3.6 times the rate of potentially avoidable emergency admissions for ambulatory care sensitive conditions (Dorning *et al* 2015).
- Inadequate treatment of mental health problems among general hospital inpatients has been linked to higher rates of re-attendance at A&E after discharge (Joint Commissioning Panel for Mental Health 2013).
- Poor management of persistent physical symptoms adds to pressures in primary care, with these symptoms being present in up to 30 per cent of all GP consultations (Kirmayer *et al* 2004).
- Dementia, depression and other mental health problems can make providing services for older people with multiple health problems significantly more complex.

Financial costs

- Co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem (Naylor *et al* 2012).
- Between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year (Naylor *et al* 2012).
- Persistent physical symptoms are estimated to cost the NHS around £3 billion each year (Bermingham *et al* 2010).
- The lifetime effects of perinatal mental health problems cost the NHS an estimated £1.2 billion for each annual cohort of births (Bauer *et al* 2014).

Figure 3 **Mechanisms through which physical and mental health interact**



Source: Naylor *et al* 2016

The new models of care introduced by the Forward View represent the most ambitious attempt yet to dissolve traditional boundaries in the NHS, in particular by bringing together fragmented budgets and services into coherent local systems of care (NHS England *et al* 2014). These innovations create an important opportunity to deliver whole-person care that responds to people's mental and physical health needs together.

> *The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries.*

To put this vision into practice, a number of new care models are being developed and tested in 50 vanguard sites across England, supported by an investment of more than £330 million over three years (ending in 2017/18). These care models create a new platform to support integrated working, including in relation to mental health. Particularly relevant to the goal of developing integrated care are the MCP and PACS models, as well as the related primary care home model (*see* box, p 10). The policy ambition is that most of the population will be covered by a PACS or MCP model or similar within the next few years. These models will be rolled out beyond the vanguard sites through the 44 STPs that have been developed across England (NHS England 2016f).

New care models in the vanguard sites and beyond

In the vanguard sites

- **Multispecialty community providers (MCPs).** GP practices in a local area are grouped into a number of neighbourhood clusters, each covering a population of 30,000 to 50,000. In each neighbourhood, a multidisciplinary team is established to allow GPs to work together with other health and social care professionals to provide more integrated services outside of hospitals. These teams might include some specialists currently working in acute hospitals, as well as nurses, mental health professionals, community health services and social workers.
- **Primary and acute care systems (PACS).** A single entity or group of providers takes responsibility for delivering a full range of primary, community, mental health and hospital services for their local population, to improve co-ordination of services and move care out of hospital where appropriate. The PACS model is fundamentally similar to the MCP model but is wider in scope (potentially including a greater range of hospital services) and may also be bigger in scale as a result.
- **Urgent and emergency care models.** These focus on improving the co-ordination of urgent and emergency care services and reducing pressure on A&E departments. Changes include the development of hospital networks, new partnership options for smaller hospitals and greater use of pharmacists and out-of-hours GP services. In 2017, in addition to their existing remit, sites implementing urgent and emergency care models were selected to test new models of mental health crisis care for children and young people, supported by an additional investment of £4.4 million.
- **Acute care collaboration models.** These involve linking hospitals together to improve their clinical and financial viability, reducing variation in care and improving efficiency. Several of the ACC vanguards are focused on developing networked approaches towards a specific clinical area such as cancer, orthopaedics or neurology. There is one ACC vanguard focused on mental health – the MERIT vanguard (*see* 'Aims and methodology' section, p 17).
- **Enhanced health in care homes models.** These involve NHS services working in partnership with care home providers and local authority services to develop new forms of support for older people.

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New care models in the vanguard sites and beyond *continued*

Beyond the vanguards programme

- **Primary care homes.** Scaled-up primary care based on multidisciplinary teams serving populations of 30,000 to 50,000. These units also form the basic building blocks of MCP and PACS models, but the primary care home model is often smaller in scale and potentially involves less structural or contractual change. Primary care homes are not formally part of the vanguards programme but are closely related, and are currently being tested in 15 pilot sites across England as part of a programme led by the National Association of Primary Care and the NHS Confederation.
- **New care models in tertiary mental health services.** Six sites across England are trialling a new model of care that enables secondary providers of mental health services to manage care budgets for tertiary mental health services (for example, secure services or specialised services for children and young people). The aim is to improve outcomes and reduce the need for out-of-area placements.

The need to develop more integrated approaches to mental health was reinforced by the Forward View for Mental Health, which placed significant emphasis on integration as part of a national strategy for improving mental health (Mental Health Taskforce 2016) (*see* box, p 12). In response to this, NHS England announced plans to invest in various forms of integrated support, including through mental health liaison services in acute hospitals, integrated perinatal mental health care, psychological therapy services for people with long-term conditions, and improved access to physical health assessment and follow-up for people with severe mental health illnesses (NHS England 2016b). The focus on integration was also included in guidance to STP leaders, which stated that their plans should include work on 'supporting physical and mental health needs in every interaction' across the whole system, including through new models of care (NHS England 2016e).

Parallel to these developments, new opportunities to incorporate mental health in work on integrated care have also been identified in other countries. The rise of accountable care organisations (ACOs) in the United States has created similar opportunities to address mental health, physical health and other needs as part of

the same care pathways. These reforms are intended to provide greater flexibility in terms of how resources are allocated and how different staff groups are used. A number of authors have argued that many of the first waves of ACOs have missed the opportunity to make mental health a central part of their work from the outset, and that there is a lack of adequate policy incentives for them to do so (Kathol *et al* 2015; Lewis *et al* 2014, p 20; O'Donnell *et al* 2013). As new models of care are adopted across increasingly large parts of the English NHS, it is important to ensure that we learn from these missed opportunities and do not repeat them. This is particularly pertinent given the intention to develop accountable care systems (seen as a step towards the ACO model) in a number of areas of the country, with NHS England and NHS Improvement providing support to local systems moving towards this approach (NHS England 2017).

Forward View for Mental Health

The Mental Health Taskforce, set up by NHS England in March 2015, was tasked with developing a five-year, all-age national strategy for mental health in England to 2020, aligned to the Forward View. Its final report, *The five year forward view for mental health*, published in February 2016, marked the first time that a shared national ambition for mental health had been set for the arm's length bodies of the NHS, supported by a pledge to invest an additional £1 billion per year by 2020/21.

The report made 58 recommendations on: prevention; improving the quality and accessibility of care; innovation and research; workforce; data and transparency; incentives, levers and payment; and regulation and inspection. The taskforce also recommended a series of access and waiting time standards to be achieved by 2021. Specific commitments include the following.

- 30,000 more women each year will have access to evidence-based specialist mental health care during the perinatal period.
- 70,000 more children and young people will be able to access high-quality mental health care when they need it.
- An additional 600,000 adults with anxiety and depression will have access to integrated evidence-based psychological therapies, resulting in at least 350,000 people completing treatment.

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Forward View for Mental Health *continued*

- 60 per cent of people experiencing a first episode of psychosis will be treated with a care package approved by the National Institute for Health and Care Excellence (NICE) within two weeks of referral.
- 280,000 more people living with severe mental illnesses will have their physical health needs met each year through early detection and by expanding access to evidence-based care.
- An additional 29,000 people per year living with mental health problems will be supported to find work or stay in work through increasing access to psychological therapies for common mental health problems and doubling the reach of employment support using the Individual Placement and Support (IPS) model.
- Crisis resolution and home treatment teams will deliver 24/7 care and at least half of all acute trusts will deliver 'core 24' liaison psychiatry.

The Forward View for Mental Health and the subsequent implementation plan (NHS England 2016b) included a significant focus on integrated approaches to mental health, including ambitions to expand access to psychological therapies in primary care for people with long-term conditions, to strengthen liaison mental health services in general acute hospitals, and to develop integrated perinatal mental health services.

2 Aims and methodology

This report explores what an integrated response to mental health in the context of new models of care could look like. It is based on research conducted jointly by The King's Fund and the Royal College of Psychiatrists. Our research focused on a number of issues, including:

- how vanguard sites are developing integrated approaches to mental health
- the relative level of priority being placed on this
- lessons that are applicable to other parts of the country adopting new models of care
- the impact of changes made so far.

The research was based on the following methodological components:

- scoping interviews with leaders from 22 vanguard sites
- in-depth stakeholder interviews in a sub-set of three selected vanguard sites
- an expert workshop and roundtable event
- insights from the Vanguard Expert Reference Group at the Royal College of Psychiatrists.

Scoping interviews

We contacted leaders in all 50 vanguard sites to ask for information on the mental health components of their work. Scoping interviews were then conducted with leaders from 22 sites between December 2015 and October 2016, either by telephone or through a site visit. In January 2017, we also conducted a survey of project managers leading the vanguard sites to gather further evidence of progress made in relation to mental health. In total, we collected information from 29 vanguard sites, listed below.

MCP vanguards

- All Together Better Sunderland
- Better Local Care (Southern Hampshire)
- Dudley Multispecialty Community Provider
- Rushcliffe Multispecialty Community Provider
- The Connected Care Partnership (Sandwell and West Birmingham)
- Tower Hamlets Together
- Wellbeing Erewash
- West Cheshire Way
- West Wakefield Health and Wellbeing Ltd

PACS vanguards

- Harrogate and Rural District
- My Life a Full Life (Isle of Wight)
- North East Hampshire and Farnham
- Northumberland Accountable Care Organisation
- Salford Together
- South Somerset Symphony Programme
- Wirral Partners

Urgent and emergency care vanguards

- Cambridge and Peterborough
- Greater Nottingham System Resilience Group
- Leicester, Leicestershire and Rutland System Resilience Group
- North East Urgent Care Network
- Solihull Together for Better Lives

Acute care collaboration vanguards

- Developing One NHS in Dorset
- Foundation Healthcare Group (Dartford and Gravesham)
- Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) (West Midlands)
- Moorfields
- The Neuro Network (The Walton Centre, Liverpool)

Enhanced health in care homes vanguards

- Airedale and Partners
- East and North Hertfordshire Clinical Commissioning Group
- Gateshead Care Home Project

In-depth case study interviews

On the basis of our scoping work, we selected three case study sites where initial discussions indicated that there was a relatively substantial focus on mental health integration as part of the vanguard work. These were:

- North East Hampshire and Farnham PACS vanguard
- Tower Hamlets Together MCP vanguard
- West Cheshire Way MCP vanguard.

A profile of each is provided in Appendix B.

In these three sites, we conducted a total of 20 qualitative interviews with a range of stakeholders between September and November 2016. We interviewed clinical and managerial staff, including frontline clinicians as well as individuals in strategic roles. The interviews included mental health and non-mental health staff.

We chose to focus our in-depth research on MCPs and PACS because the emphasis in these care models on dissolving traditional boundaries between hospital, community,

primary, social and mental health care fits most closely with our focus on integrated approaches to mental health. However, in the report, we also draw on material collected through our scoping interviews to describe relevant developments in other vanguard types, including in the urgent and emergency care vanguards, most of which have included a focus on improving mental health crisis care.

There is one vanguard in England (an ACC vanguard) that is specifically focused on mental health – MERIT. Through a partnership of four mental health providers serving a combined population of more than 3 million people, this alliance aims to improve acute mental health services by sharing best practice and developing new ways of working that are more effective, efficient and consistent. The vanguard is focusing on areas including co-ordinated emergency response, improved discharge from inpatient care and more support for recovery and relapse prevention in the community. In this report, we describe elements of the MERIT programme that relate most closely to the main themes addressed in our research, particularly those around integrated care and the relationship between mental health services and the wider system.

We did not conduct in-depth research on the 'enhanced health in care homes' vanguards, but acknowledge that many of these sites are conducting work intended to improve the way people with dementia are supported in care homes.

Stakeholder engagement

In August 2016 we held an engagement workshop involving service users and carers, a range of mental health professionals, other health and care professionals (including GPs), senior managers from provider organisations, commissioners and other stakeholders. This workshop explored what good practice might look like – including from a service user and carer perspective – and underpins the nine principles for success described in the next section.

In November 2016 a roundtable event was held at the Royal College of Psychiatrists focusing on the mental health components of urgent and emergency care vanguards. The event was attended by leaders of some of those vanguard sites, and provided a way of gathering further intelligence and testing emerging findings.

Our work was also informed by the Vanguard Expert Reference Group at the Royal College of Psychiatrists, which includes representation from the College's faculties and divisions, specialist advisers and college leads as well as from service users and carers, the Academy of Medical Royal Colleges, the Royal College of General Practitioners and the National Collaborating Centre for Mental Health.

Further to this, in January 2017 we contacted clinical associates working in the new care models team at NHS England, as well as mental health leads in strategic clinical networks across England, in order to gather further information about mental health plans across the vanguard programme.

3 Nine principles for success

We wanted to start with an understanding of what, in principle, successful integration of mental health within new models of care would look like. The engagement workshop with frontline staff, service users, carers, providers, commissioners and relevant national stakeholders (held in August 2016) aimed to identify design principles to guide the development of integrated approaches to mental health through new models of care.

Drawing on the views and experiences of workshop participants, we identified nine key principles for successful integration of mental health in new models of care. Local system leaders can use these principles to help ensure that integration of mental health is a core part of the development of new care models, and to capitalise on the opportunities this presents.

1. The commissioning, design and implementation of new models of care should be consistent with the requirement to deliver parity of esteem.

The requirement to deliver parity of esteem, defined as 'valuing mental health equally with physical health', has been laid out in legislation and numerous policy documents over recent years. It is characterised by: equal access to the most effective and safest care and treatment; equal efforts to improve the quality of care; the allocation of time, effort and resources on a basis commensurate with need; equal status within health care education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes (Royal College of Psychiatrists 2013). These principles must be reflected throughout the development of new models of care.

2. Mental health should be considered from the initial design stages of new models of care.

The fundamental changes needed are likely to be harder to achieve if mental health is added onto pre-existing plans that have not considered it from their inception. To achieve meaningful integration of mental health in new care models, it must be a key consideration throughout the entire development process, including during the early design phases.

3. New care models should address and measure outcomes that are important to patients and service users, identified through a process of co-design.

It is important that new models of care address outcomes that are important to service users and carers, in addition to outcomes designed to bolster the financial sustainability of the system. Co-designing the care model with people using services and the wider local population is an essential part of this. Meaningful public engagement is necessary to identify the outcomes that are most important to the population being served, and the design of new care models should then follow from these priorities. Once the care model is implemented, progress against these outcomes should be measured systematically and include patient-reported measures.

4. New care models should take a whole-person approach spanning an individual's physical, mental and social needs.

New models of care should focus on delivering whole-person care that supports mental health alongside other aspects of health, rather than being addressed in isolation. This requires attention to the full range of an individual's needs, including their psychological and social needs – regardless of whether their primary health need is mental or physical in nature. As part of this, there needs to be a clear understanding among those involved in developing new models of care that mental health is about more than mental illness; good mental health is a key determinant of other outcomes and should be considered as a routine part of care.

5. New models of care should extend beyond NHS services to include all organisations that may impact on people's health and wellbeing.

Relationships and networks should be built with a variety of partners, not only those delivering NHS-funded services. Key partners include social care, housing and voluntary sector organisations as well as employers and the education system, all of which can play an indispensable role in relation to mental health. Through bringing together parts of the wider system, new models of care can capitalise on the full range of assets in an area.

6. Invest in building relationships and networks between mental and physical health care professionals.

New care models should be designed in a way that helps to break down the barriers between organisations and individuals. This will require an explicit focus on strengthening relationships at all levels, including between senior leaders from different organisations as well as between frontline staff from different professions and provider organisations.

7. New models of care should enhance the provision of upstream, preventive interventions to improve mental health and wellbeing.

Strengthening prevention should be a key focus for new care models, including primary, secondary and tertiary prevention. For example, integrated care teams established as part of new care models should aim to address the range of factors (including social and environmental factors) that shape the mental and physical health and wellbeing of the people they are serving.

8. Every clinical interaction should be seen as an opportunity to promote mental and physical wellbeing.

All interactions between health care professionals and members of the public represent valuable opportunities to help people improve their mental and physical wellbeing. Staff should be equipped with the necessary knowledge, information and skills to initiate conversations with people about their mental wellbeing, to encourage positive behaviour change, and to signpost to local support resources.

9. All frontline staff should receive appropriate training in mental health, regardless of the setting in which they work.

Training should equip staff to recognise and manage common mental health problems at different stages in the life course, and to understand the psychological components of physical illness. Where appropriate, education and training should be conducted on an inter-professional basis, bringing together staff working in physical and mental health care settings to share their knowledge and expertise.

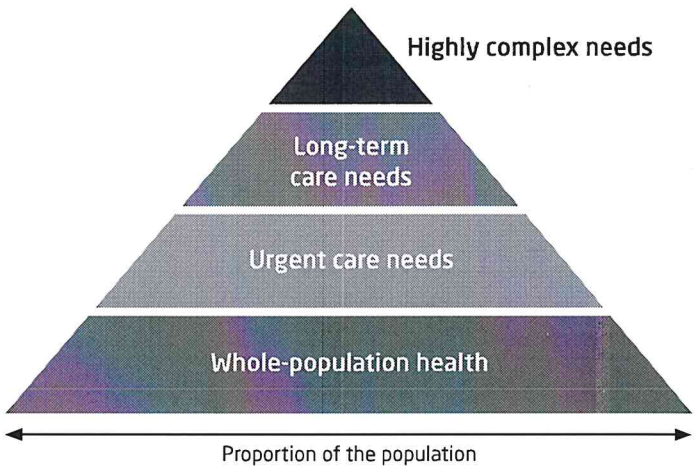
These nine principles provide an overview of the approach to mental health integration that key stakeholder groups would like to see implemented through new models of care. In the next section, we explore the approaches being taken to mental health integration in a number of vanguard sites, providing insights into how some of these principles may be applied in practice.

4 Mental health in new models of care: examples from the vanguard sites

This section describes examples of how mental health is being incorporated into new models of care, primarily drawing on our research in two MCP vanguards and one PACS vanguard (*see* Aims and methodology section, p 16). Where relevant, we also include intelligence gathered from other vanguard sites, including some of the urgent and emergency care vanguards.

This section has been structured according to the framework that MCPs and PACS are expected to operate within (NHS England 2016c, 2016g). The framework describes how successful MCP and PACS models involve making changes at four levels, as shown in Figure 4.

Figure 4 The four levels of the MCP and PACS care models



Source: Adapted from NHS England 2016c, 2016g

The section concludes by describing the supporting infrastructure that has been developed to enable changes at each of these levels. Our intention is not to provide a comprehensive stocktake of all relevant developments, but rather to illustrate the range of work being done on mental health in vanguard sites, and to highlight some of the most common components.

Highly complex needs

A major focus of work on new models of care has been the development of improved support in the community for people with highly complex care needs. This often includes older people with frailty, people with multiple long-term conditions and high social care needs, and people receiving end-of-life care. Services being developed for these groups are typically targeted at a small fraction (2–5 per cent) of the population who use health and social care services most frequently.

The main approach seen in the vanguard sites and elsewhere to improve care for people with highly complex needs is the development of integrated care teams covering a local area or 'neighbourhood'.

Neighbourhood or locality-based integrated care teams form the mainstay of MCP and PACS models, and are also the basis of the primary care home model. These multidisciplinary teams typically cover populations of 30,000 to 50,000, and bring together a range of community health and social care professionals working alongside a cluster of GP practices. In most MCPs and PACS there is some form of mental health input into these teams, but arrangements vary considerably. Some sites have chosen to fully embed mental health professionals into integrated care teams, whereas others have arrangements in place for consultation and liaison with staff in separate mental health teams.

Many integrated care teams focus primarily (although often not exclusively) on older people. As such, there has been a particular emphasis on securing expertise in relation to older people's mental health. This includes advice about dementia management as well as other conditions common among older people, such as depression.

In North East Hampshire and Farnham PACS, mental health expertise is directly embedded in locality integrated care teams. There are currently 2.3 full-time equivalent (FTE) mental health professionals (two nurses and one occupational

therapist) working across five integrated care teams. These individuals are involved in discussion of all cases at weekly referral meetings and multidisciplinary team meetings, and carry their own caseload. Their primary focus is on older adults with co-morbid physical and mental health conditions, but the intention is that the client group served will widen as the care model develops. They receive monthly clinical supervision from a consultant psychiatrist, who they can also contact for specific advice (eg, in relation to medications).

Similar arrangements have been developed in Harrogate and Rural District PACS, where each community care team includes a mental health practitioner working alongside two district nurses, two physiotherapists, two occupational therapists, a pharmacist and a social care assessor.

In Tower Hamlets Together MCP, a senior community mental health nurse is included in each integrated community health team. Linked with GP practices, these teams provide co-ordinated health and social support to all patients over the age of 18 identified as having complex needs. This includes anybody on the primary care registers for dementia, palliative care or living in a care home, as well as people who have been identified by their clinician as needing a multidisciplinary approach. The mental health nurses are supported by a half-time consultant psychiatrist working specifically as part of the integrated care programme. The nurses attend practice-based multidisciplinary team meetings to help identify patients who potentially have a mental health problem that may be exacerbating their physical illness. They also provide brief support and treatment to patients requiring additional input, along with consultation and training to community health teams and primary care professionals. The teams also support care homes in the borough to deliver person-centred care for people with dementia.

West Cheshire Way MCP is using a different model, involving link worker arrangements designed to enable the integrated care teams to work in liaison with mental health professionals. Two main sources of support are available. First, for older adults, each locality is supported by a designated mental health nurse in the local older people's mental health team. Members of the integrated care team can contact their named clinical lead by phone for advice, and the lead may be invited to participate in a case discussion in a multidisciplinary team meeting. Second, for working-age adults, each of the integrated care teams has a link worker in the primary care mental health service (*see* below).

A related approach used in some vanguard sites is the 'extensive care' model, developed for supporting people with the very highest levels of care needs. The model involves an 'extensivist' (usually a community geriatrician or GP) assuming overall clinical responsibility for a person's care from their general practice. The extensivist works alongside a multidisciplinary team to address all aspects of a person's care in a co-ordinated way. As part of the Fylde Coast MCP an extensive care service has been developed in Blackpool aimed specifically at people with complex mental health needs, substance abuse and/or social problems.

Long-term care needs

A central concern of work on new models of care has been to improve care for people with long-term conditions and other ongoing care needs. These services are typically targeted at the 20 per cent of the population who use health and social care services most frequently (ie, a broader group than those with highly complex needs, focused on in the previous section).

The aim is to provide a broader range of services in the community that integrate primary, community, social and acute care services, and bring together physical and mental health. In addition to the integrated care teams described earlier (which often focus on both complex and long-term care needs), other approaches being implemented include enhanced mental health provision in primary care, social prescribing, and programmes to support personal recovery.

Enhancing mental health provision in primary care

A number of vanguards are enhancing the mental health support and expertise available in primary care. For example, one component of the West Cheshire Way MCP has involved strengthening the local primary care mental health service. This service is delivered primarily by community psychiatric nurses, nurse therapists and psychologists. As part of the vanguard programme a consultant liaison psychiatrist has been added to the team, who splits their time between the primary care and acute hospital liaison services. This has enhanced the service's ability to support people with co-morbid physical and mental health problems, chronic pain and other persistent physical symptoms. The vanguard work has also involved setting up a link worker arrangement with local integrated care teams, as described earlier in this section.

Tower Hamlets Together MCP, working with partners in neighbouring boroughs, has developed a primary care mental health service supporting the discharge of people with stable serious mental illness to primary care, and providing step-up support to people from primary care. The service includes a contract with practices to provide additional support for service users with a focus on healthy lifestyles, along with a team of primary care-based mental health professionals. The model is reported to have brought about a significant improvement in communication between secondary and primary care, with regular practice-based multidisciplinary team meetings attended by consultant psychiatrists.

North East Hampshire and Farnham PACS is expanding its improving access to psychological therapies (IAPT) programme as part of the national policy drive to extend the scope of these services and to integrate them more closely with primary care. The area is one of 22 'early implementer' sites being supported to lead the way in integrating IAPT services with physical health care. The care pathways being focused on include those for persistent physical symptoms and for COPD. This does not fall directly under the vanguard, but is viewed locally as being part of the same drive to bring mental and physical health pathways together.

As part of its vanguard programme, Rushcliffe MCP in Nottinghamshire has developed a primary care psychological medicine service. This focuses on supporting people with persistent physical symptoms and others who frequently attend primary care, and is delivered by experienced liaison nurses and a liaison psychiatrist who also works in the local acute trust. Common input includes: case management; diagnosis of mixed medical and psychiatric morbidity; training, supervision and support for GPs and other professionals; and educating patients.

Accessing community resources

There has been a growing interest across the country in the use of social prescribing and related approaches to connect people with resources in their local community aimed at improving health and wellbeing, with some evaluations reporting positive results in terms of patient outcomes and service use (Dayson *et al* 2013; Kimberlee 2013). Social prescribing allows health care professionals to refer people to a range of non-clinical services to address their needs in a holistic way, and often focuses on improving mental health and wellbeing. Vanguard sites have developed various approaches towards supporting people to access these kinds of resources.

In North East Hampshire and Farnham PACS, the Making Connections programme includes Making Connections workers (a new role delivered through the voluntary sector) based in general practices. These individuals act as navigators and can connect people to local resources as well as helping them to identify and access voluntary services in the community that may improve their health and wellbeing. This enhances the non-clinical support available to patients and service users, and provides GPs and professionals in the integrated care teams with an additional type of support to offer.

West Cheshire Way MCP has introduced a similar role – that of wellbeing co-ordinators – in each integrated care team. These staff are reported to play a critical role in promoting positive mental health and wellbeing among the people supported by the team. Their main role is to help connect people with local voluntary and community sector services – particularly people who are at risk of social isolation and are in need of some extra support, or who are known to be experiencing emotional distress. The intention is both to prevent the development of mental health problems, and to support the recovery of those with existing mental health problems. The aspiration is to widen the wellbeing offer in the integrated care teams over time, with the addition of peer-coaches, self-management courses and (potentially) other resources such as dementia care navigators.

Tower Hamlets Together MCP is establishing four 'wellbeing hubs' across the borough to provide a single point of access to information on health, wellbeing, social and other resources available within the local community, as well as providing links to key services such as public health, social care, and voluntary and community sector organisations. Once established, it is expected that these hubs will hold detailed information on local mental health provision and will be able to direct people to appropriate services. Similarly, professionals in mental health services will be able to signpost their clients to the wellbeing hubs for support in addressing their wider needs, including lifestyle services, health trainers and employment support among a range of other services.

A related approach is 'local area co-ordination', currently being used by the My Life a Full Life (Isle of Wight) PACS vanguard. Co-ordinators are recruited from the local community and are responsible for developing detailed knowledge of the

various assets available in an area (usually covering a population of around 12,000). Co-ordinators work with people with mental health needs, disabled people and older people at risk of loneliness and isolation. They help people to identify their strengths and skills and make use of these in their local community, reinstate their social networks and build new relationships, and explore what a 'good life' would look like for them.

Supporting personal recovery

The concept of 'recovery' in mental health has been defined as 'living a satisfying, hopeful and contributing life even with the limitations caused by illness' (Anthony 1993). Enabling personal recovery has been a focus for mental health services for many years, and some vanguards are building on this by introducing or expanding services that focus on support for recovery.

One increasingly common approach is the development of peer-led 'recovery colleges' to share knowledge and evidence about recovery, self-care and self-management (Burhouse *et al* 2015). In North East Hampshire and Farnham PACS, the recovery college model has been expanded as part of the vanguard's work. Originally developed for individuals living with long-term mental health problems, the remit of the college has extended to focus on both mental and physical health, and there is a dedicated course exploring the links between the two. Work is ongoing to further develop the offer, particularly to enhance the focus on physical health, wellbeing and prevention.

Developing more effective ways of supporting recovery is also a component of the work being done by the MERIT vanguard, with the aim of preventing relapse and readmission wherever possible. The alliance is exploring how resources and assets in local communities can be mapped more systematically and used to help people in their recovery. Part of this involves thinking about the role of employers in supporting people back into work, including through the provision of mental health first aid training to local employers.

Urgent care needs

In addition to improving services for people with highly complex and ongoing care needs, many of the vanguards are redesigning urgent and emergency care services. This is obviously a key focus in the urgent and emergency care vanguards but has also been given attention in some MCP and PACS sites.

Many of the urgent and emergency care vanguards are expanding their psychiatric liaison service to meet the 'core 24' standards, making the service available 24 hours a day, 7 days a week (Aitken *et al* 2014). While this is a requirement of the Forward View for Mental Health (Mental Health Taskforce 2016), some of the urgent and emergency care vanguards are using this as an opportunity to expand psychiatric liaison services further. For instance, the Leicester, Leicestershire and Rutland System Resilience Group urgent and emergency care vanguard is incorporating consultant psychiatrists into its mental health triage nurse service and the frail older people's assessment and liaison service. The liaison psychiatry service will also align with the alcohol team based in the emergency department.

Other developments seeking to better integrate mental health into urgent care pathways include the following.

- Safe Havens in North East Hampshire and Farnham were initially introduced as a short-term pilot in 2014 but have now been expanded through the vanguard programme. These services provide a safe space for people who are at risk of a mental health crisis, seven days a week, in community settings. The model is also being adopted in the Isle of Wight vanguard and elsewhere.
- Cambridgeshire and Peterborough urgent and emergency care vanguard has developed a First Response Service that directs 111 callers to 24/7 support and mental health crisis response. The service consists of: experienced psychological wellbeing coaches who provide initial assessment via telephone; a co-ordinator who oversees the coaches and co-ordinates calls from emergency services; and first responders (mental health nurses or social workers) who provide face-to-face assessment and crisis management.
- Many vanguard sites (and other areas of the country) are seeking to improve the care people receive when in contact with the police. For example, in Cambridgeshire and Peterborough urgent and emergency care vanguard, a mental health practitioner is present in the police control room between

8.00am and 10.00pm (weekdays) and between 1.00pm and 9.00pm (weekends) providing advice to frontline officers.

- In Leicester, Leicestershire and Rutland urgent and emergency care vanguard, a street triage service staffed by police officers, paramedics and mental health nurses operates three days a week (Friday to Sunday). Currently, 50 per cent of the people who are in contact with the service are taken to A&E; the vanguard aims to reduce this to 12 per cent.
- The MERIT vanguard is developing a co-ordinated emergency response system across the four participating mental health trusts, with the aim of reducing the time people who come into contact with mental health services spend unnecessarily in A&E or police cells. This involves the introduction of standard operating procedures as well as making systems more flexible so that crisis care is provided in a consistent and efficient way. One aspect of this is the introduction of a new bed management system that will allow professionals working across mental health services to better manage beds in order to reduce inappropriate out-of-area placements.

Whole-population health

Guidance from NHS England is clear that MCPs and PACS have an important role to play in reducing future demand on services through health promotion activities and the prevention of ill health. However, we found few examples of MCPs and PACS conducting work intended to improve the health of the whole local population, particularly in relation to mental health.

Tower Hamlets Together provides one example of a vanguard site aiming to progress towards a population health management approach involving both mental and physical health. As part of this work, the main mental health provider involved in the vanguard (East London Foundation Trust) has recruited a public health lead to support the development of more integrated preventive pathways, working alongside a public health consultant reporting to the Tower Hamlets Together partnership. The box below provides further detail on some of the work being done to underpin population health management in Tower Hamlets Together.

Wider work being conducted in some vanguard sites may have an impact on population mental health and wellbeing over time. For example, in the Morecambe

Bay PACS vanguard several initiatives are under way aiming to support local people to take part in and lead activities that promote their health and wellbeing, such as community-led 'wellness days' in Barrow-in-Furness. By reducing social isolation and improving general health and independence, initiatives of this kind may also have a positive effect on mental health outcomes.

Population health management in Tower Hamlets Together

Population-level data

In order to understand health inequalities and health service utilisation across the borough, Tower Hamlets has created a linked dataset with patient-level information from acute services, primary care, primary care prescribing, social care, mental health, community services and continuing health care. Other areas of health and social care activity, including public health and specialised commissioning, are to be incorporated in future. This has enabled Tower Hamlets Together MCP to accurately assess how mental health conditions impact on activity and costs across the system.

Initial work has focused on how activity and cost differ for people across four primary care registers (depression, dementia, serious mental illness and learning disabilities) alongside four long-term condition pathways (diabetes, COPD, cancer and chronic kidney disease). This analysis is helping to shape the development of new whole-person pathways. For example, the organisations involved are currently developing 'test and learn' pilots of a consultant psychiatrist role within renal outpatients, and health psychologists to support people with diabetes in GP practices.

Realigning incentives through new approaches to reimbursement

The linked dataset in Tower Hamlets was created to support plans for a new contractual approach based on a capitated budget. Local providers are now beginning to use the dataset to help understand how linked data can support clinicians to redesign pathways and services, and to understand the quality, strategic, commercial and financial opportunities and risks of a capitated approach to contracting.

As a first step in testing how financial risks and opportunities might be shared across the provider partnership, the partners have been working together to deliver against a shared

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Population health management in Tower Hamlets Together *continued*

local incentive scheme in 2016/17. This scheme places £1.7 million of provider income at risk and makes available a potential £1 million benefit to providers, dependent on the delivery of 10 outcome goals over the course of the year. Two of these relate to mental health: emergency admissions for people with depression, serious mental illness or dementia; and total bed days for the same groups.

In 2016/17 there was a statistically significant 12.7 per cent reduction in occupied bed days for people with depression, serious mental illness and dementia, while rates of emergency admissions have remained static. The intention now is to incentivise outcomes for emergency admissions through a new community health services alliance contract, and discussions are under way with the clinical commissioning group (CCG) about a reward pool against a similar set of metrics for 2017/18.

System-wide outcomes framework

Tower Hamlets partners are currently working with service users, carers, citizens and clinicians to develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for people who live in the borough. It is anticipated that the partners will begin to monitor performance against the outcomes framework during 2017/18.

Supporting infrastructure

Vanguard sites have invested in various forms of infrastructure to support the kind of service changes described earlier in this section. This has included redesigning the workforce, and using technology in new ways to improve the delivery of care.

Developing new and extended roles

Many vanguard sites have explored new and extended roles as part of new models of care, including care navigators, case managers, hybrid health and social workers, health and social care co-ordinators, discharge co-ordinators based in acute wards, recovery coaches (with lived experience of mental illness), and a variety of roles provided by voluntary sector partners focused on supporting wider wellbeing. These kinds of workforce innovations are a common feature of work on integrated care,

although in some cases there is a need for more evidence on the impact of these new roles on patient outcomes (Gilburt 2016a).

Many of the extended roles identified in our case study sites involved the appointment of senior (band 7) mental health nurses into integrated care teams. Seniority was seen as being important given the need for these professionals to work across different services in a highly autonomous and flexible way.

Tower Hamlets Together MCP has developed a competency set for new and extended roles to define the integrated care skills that mental health professionals need, as well as the mental health skills that community teams need in order to do their job safely and effectively. This includes: history-taking and mental state examinations; engagement skills and principles around building a positive therapeutic relationship; risk assessment and management; recovery-oriented care; and dealing with psychiatric emergencies. Those involved are now working with Bournemouth University to turn these competencies into a training package for GPs and practice nurses with a focus on managing severe mental illness in primary care.

The MERIT vanguard is also reviewing the training needs and skill-mix of its staff in order to deliver mental health services that are more consistent across a number of sites. As part of this they are considering how staff may work more flexibly across the four trusts involved in the alliance.

Informatics and technology

Several vanguards have sought to address issues with informatics and technology – for example, in relation to the interoperability of IT systems. In North East Hampshire and Farnham PACS, the Hampshire Health Record allows GPs to see a more comprehensive picture of a patient's history. This means they can share patient information within the system, and staff in A&E and out-of-hours services can view GP records, past medical history, medication lists and allergies. The vanguard site is working towards having a shared care record for all services across the vanguard area, including mental health services.

Similarly, West Cheshire Way MCP is using a shared care record in the integrated care teams but this is still read-only; the team do not have a shared care plan that they can all edit dynamically.

The acute care collaboration vanguard, MERIT, is introducing an integrated patient record system in 2017 across the four participating mental health trusts, to ensure that service users receive rapid support, wherever they are and regardless of which trust's area they come from.

In addition to shared care records, some vanguards are rethinking how care is delivered through digital technology. For instance, MERIT is also planning to introduce a co-ordinated bed management system across the four participating trusts. This will enable staff to identify where beds are available using visual electronic boards to provide 'at a glance' information. The aim is that patients are less likely to be placed in a bed outside the area.

Summary

The range of developments reviewed in this section illustrates the progress that has been made in some vanguard sites in integrating mental health into new models of care for people with highly complex needs, ongoing long-term and/or urgent care needs. These examples may be helpful to local system leaders when designing new models of care. The next section focuses on delivery, as we examine some of the practical lessons learnt across our three case study sites.

Some of the developments described are consistent with known best practice and guidance. For example, there is an established evidence base behind models such as 'core 24' liaison psychiatry. In other cases, there is a need for more evidence about what works. For example, as discussed in the next section, it remains to be established what best practice would look like in relation to incorporating mental health expertise into integrated care teams. These evidence gaps highlight the importance of adequately evaluating the mental health components of new care models – a theme we return to in section 6.

5 Emerging lessons for local system leaders

There is no simple rulebook to guide successful integration of mental health within new models of care. However, based on our research in several vanguard sites, we have identified some practical lessons that will be relevant for local leaders involved in the development of new models of care in other parts of the country. As MCPs, PACS and other models are rolled out in new areas (including through the implementation of STPs), these emerging lessons provide timely insights into some of the key factors that need to be considered.

As with the previous section, the analysis here is based primarily on research conducted in three case study sites (*see* Appendix B) but also draws on interviews with leaders in other vanguard sites. Appendix A gives a list of useful resources for commissioners and system leaders relating to the integration of mental health care.

Incorporating mental health into integrated care teams

The value of including mental health in integrated care teams was clear for those interviewed in our case study sites. GPs and multidisciplinary team members reported that they found the contribution of mental health colleagues extremely valuable, and adding extra in-house capacity and/or developing arrangements for closer working with other mental health teams was seen as a high priority for future service improvement. In several sites, there was an ambition to increase the level of mental health input over time, in recognition of the high levels of demand among the population groups served.

Mental health expertise was seen as adding value to the work of integrated care teams in a number of ways, including through:

- supporting a more holistic assessment of people's needs
- improving care for people with complex needs, including depression or other mental health problems alongside co-morbid and multimorbid physical conditions
- improving psychological aspects of care for anyone supported by the team (*see* 'Broadening the scope of mental health' below)
- improving dementia management
- providing consultation and training to community health teams and primary care professionals.

It remains to be seen whether the best approach is always to embed mental health professionals within multidisciplinary teams or whether it can also be effective to seek input as and when needed through consultation/liaison arrangements (or a combination of the two). Professionals working in a fully embedded model argued that it can be very helpful for mental health colleagues to be able to contribute to all case discussions, regardless of whether a person has an identified mental health problem. However, some mental health trusts expressed concern that their workforce would be spread too thinly if teams were fragmented across a number of local integrated care teams, each covering a relatively small population. They feared that this could create challenges in terms of supervision arrangements, professional development, and recruitment and retention, as well as loss of economies of scale.

The optimal number and professional mix of mental health staff within these teams is not yet clear. Where mental health professionals are fully integrated, at present this is generally limited to a relatively small number of nursing staff. In some cases, consultant psychiatrists have been linked to these teams to provide consultation and advice. Some integrated care team members remarked that it would also be helpful to have access to psychologists, either in-house or through close relationships with other teams.

Broadening the scope of mental health

Building on these experiences, when developing new models of care it is important to recognise that mental health expertise can add value to the care of a broad range of people, including but not limited to those with a diagnosable mental health problem. Many of the examples from the vanguard sites serve a wider population, and illustrate that knowledge and skills around psychology and mental health are important ingredients of integrated care, whatever the client group. Ensuring integrated care teams have access to these forms of knowledge and skills allows teams to:

- understand the psychological aspects of care – for example, the impact of psychological factors on engagement and capacity to self-manage
- provide care to people with 'sub-threshold' symptoms (such as distress, fear or loneliness) that do not meet psychiatric diagnostic criteria but which may nonetheless be highly debilitating and detrimental to physical health
- help people to adjust psychologically to the challenges of living with a long-term condition (or multiple conditions)
- improve the management of persistent physical symptoms where there is an interaction with psychological factors.

Focusing on prevention as well as care

Several of the vanguard sites involved in our research have attempted to use the development of new models of care as an opportunity to strengthen the provision of preventive interventions, such as improving the mental health and wellbeing of people receiving support from integrated care teams and preventing further deterioration in their condition. This has often involved working closely with the voluntary sector.

For example, the wellbeing co-ordinator role in integrated care teams in West Cheshire Way MCP is highly valued and is seen as having had a very positive impact on people supported by the team. As a result, there are plans to expand the wellbeing offer over time (*see* section 4). Similarly, in North East Hampshire and Farnham PACS, the Making Connections programme (run in partnership with Age UK) has been seen as a successful way of connecting people with non-medical

and community services to improve their health and wellbeing, and enabling GPs and integrated care teams to offer an additional type of support. In these examples, voluntary sector organisations are increasingly being seen as a core part of the delivery system rather than as an external partner.

The sites we studied had also partnered with their local authority, and had made links with the local health and wellbeing boards. However, we did not find examples where preventive work had made full use of local authority services such as debt advice, employment support, fire service and housing. This is an area where future care models could extend their scope in order to strengthen work on population health management.

Developing the workforce

Developing mental health competencies in the general health and care workforce should be a core objective for new models of care. Several vanguard sites have made attempts to strengthen the competence, confidence and skills of GPs, integrated care teams, care home staff and others in relation to mental health – although there remains much more to be done on this front to ensure that all professionals have the necessary skills. Building capacity in this way is important given the mismatch between the level of mental health needs in the population and the availability of mental health expertise. Developing the skills of non-specialists can also help to reduce the stigma attached to mental health by making it a normal part of care.

In some vanguard sites, mental health professionals involved in new models of care have had an explicit role in education and training. For example, in West Cheshire Way MCP, a new older people's consultant psychiatrist post has been created to provide educational input into the integrated care teams and primary care. In Tower Hamlets Together MCP, mental health nurses in the integrated community health team have protected time to provide training to primary care as well as to community health teams.

Inter-professional approaches can be a particularly effective way of improving skills across the workforce. For example, the North East Urgent Care Network vanguard has funded multi-agency simulation training involving mental health professionals, Northumbria Police and other partners, which has been regarded as very successful.

A further lesson in relation to workforce is that new models of care can be used to create new opportunities to promote staff wellbeing. For example, in North East Hampshire and Farnham PACS, the vanguard work has included an explicit focus on the mental health and wellbeing of the workforce, and outcome measures include indicators on this.

Building the right relationships

Developing a new model of care such as an MCP or PACS involves establishing or strengthening relationships that span system boundaries. We found that the work conducted in many vanguard sites was seen as having enabled conversations between providers that otherwise would not have happened. For example, one interviewee described the most innovative aspect of the work in North East Hampshire and Farnham PACS as being the coming together of organisations that have traditionally operated in relative isolation from one another, particularly NHS and voluntary sector organisations.

It is important to recognise that relationship-building takes time and may require cultural change within organisations. We heard that several factors can facilitate this, including direct communication, regular face-to-face meetings, co-location of integrated teams, and the alignment of strategic objectives.

Some interviewees stressed the importance of having mental health leaders 'around every table' in order to consistently keep mental health on the agenda. One reported that it was particularly helpful to have someone with recent experience of delivering mental health services within the central programme management office responsible for overseeing the implementation of a new model of care, to help identify and articulate the value that mental health expertise can add to different components of the model. There may also be value in creating strategic joint posts accountable to all partner organisations rather than working for one organisation. For example, in Tower Hamlets Together MCP, there is a public health post for the vanguard. This was reported to be particularly valuable as it creates capacity to do system-wide work across the local area.

Co-design and public involvement

The overarching purpose of developing integrated approaches to care is to effectively respond to the full range of a person's needs. Engaging with service users to identify and understand these needs and recognise the outcomes that matter to them is a prerequisite for getting the approach right.

There were several examples of public engagement in the vanguard sites included in our research, where the views of service users and carers were sought early in the design process and had a direct influence on the subsequent development of the care models. For example, co-design and service user involvement have been integral to the development of new models of care in North East Hampshire and Farnham PACS, particularly with regard to the Safe Havens and Recovery College.

Engagement can include co-design of specific service models, co-delivery of services and local representation at all levels of the vanguard work – for example, through citizen representation on working groups. Building links with the voluntary sector and local Healthwatch was seen as another way of facilitating meaningful public engagement.

Starting small and learning from experience

A common piece of advice for those involved in the development of new care models is to initiate new services on a relatively small scale, and subsequently expand them if they prove successful. This enables models to be tested and adapted if necessary. Continuous evaluation of outcomes and user feedback can help identify where changes may be required.

In Tower Hamlets Together MCP, a quality improvement methodology has been used to structure this process of testing and learning. The approach taken has involved encouraging frontline teams to identify problems when rolling out integrated care and to offer solutions.

When scaling up or spreading models, it is important to retain experience and learning. Some of the vanguard sites involved in our research told us they had benefited from maintaining consistent leadership and 'organisational memory' – for example, by ensuring that service managers that have been involved in the design and running of the pilot phase are also involved in scaling up the model.

6 What next?

The new models of care being developed in the vanguard sites have been described by NHS England as 'a blueprint for the future of the NHS' (NHS England 2016d). Given the strategic significance of these models, it is worth standing back from the details described in the previous sections and reflecting on the overall picture. In this section, we consider the extent to which the opportunities to develop integrated approaches to mental health within new models of care have been realised in practice. We also explore what needs to happen next as these models are rolled out across the rest of England through STPs and other mechanisms.

Progress so far

National policy has been clear that one of the objectives of the new care models programme is to dissolve the boundaries between mental health care and the wider system. For example, guidance published by NHS England describing the emerging care models in MCP and PACS sites indicates an expectation that mental health should be an integral part of these models (NHS England 2016g, 2016c). However, while this general principle may have wide support, our research found that it has not consistently been put into practice.

The examples we provided in section 4 illustrate that in some vanguard sites there has been a focus on mental health, and some concrete developments have been made as a result. It is important to acknowledge and examine these developments – many of which are ongoing processes – and to learn from them. However, it is not always clear that the changes introduced go substantially further than innovations seen in other parts of the country, or indeed than the expectations laid out in national policy. For example, many of the changes being introduced in urgent and emergency care vanguards (such as strengthening liaison psychiatry services in acute hospitals) have been identified as requirements in the Forward View for Mental Health as well as in NHS England's *Urgent and emergency care route map* (NHS England 2015), while other components seen in these sites (eg, street triage) are being implemented widely across England through local Crisis Care Concordat

plans. Similarly, some of the mental health components of MCPs and PACS mirror work being conducted elsewhere – for example, the Recovery College model described in section 4 is becoming increasingly common throughout the country.

It is also clear that mental health has been a higher priority in some vanguard sites than others. While many of the urgent and emergency care vanguards have included substantial mental health programmes within their work, in the acute care collaboration vanguards there appears to be little consideration of mental health (with the exception of the MERIT vanguard). This is a missed opportunity, as some of the pathways being focused on in these vanguards could benefit from a mental health component. For example, integrating mental health treatment into cancer pathways has been found to improve mental health outcomes, reduce pain and fatigue, and improve general functioning and quality of life (Sharpe *et al* 2014), and there would be value in testing such approaches as part of new models of cancer care.

It should be noted that the three MCP and PACS vanguards we studied in greater depth were chosen because our scoping interviews indicated that they included a number of mental health components. As such, they do not necessarily reflect the overall level of priority placed on mental health across the vanguard programme. And even in these sites, it was notable that staff in integrated care teams suggested that extra mental health capacity would be highly valuable, indicating that the resources available may not yet fully meet the needs that exist.

Comparing the progress observed with the nine design principles developed by our expert group (section 3), a mixed picture emerges. A notable positive finding is that in many of the sites where we conducted research, we did find evidence that the development of new models of care had helped to foster relationships and networks between health care professionals working in mental health and physical health, at both the clinical and strategic levels (principle 6). New care models are also being used as a vehicle to provide appropriate mental health training to frontline staff – for example, in integrated care teams and primary care (principle 9). However, there is still some way to go before services are consistently providing a truly whole-person approach spanning an individual's physical, mental, emotional and social needs. As an illustration of this, integrated care teams were described in one MCP as 'predominantly a physical health service' despite the inclusion of some mental health staff.

Overall, we conclude that although important foundations have been built in several local areas, the full opportunities for integrating mental health within new models of care have not yet been realised. It should be acknowledged that the purpose of the vanguard programme was not to introduce a comprehensive package of reforms in all 50 sites, but rather to prototype and test different components of new care models across the sites involved. In relation to mental health, the critical measure of success is that taken together, the work done in the vanguard sites allows us to test hypotheses about the potential impact of integrating mental health within new models of care. Our concern is that the service changes implemented to date may not be sufficient to allow for these hypotheses to be adequately tested.

Barriers to be overcome

Attempts to develop any form of integrated care can run into barriers created by the institutional fault lines in the health and care system – non-interoperable information systems, information governance issues, difficulties pooling budgets across sectors, and difficulties finding shared premises for integrated teams, to name just a few. As might be expected, our research confirmed that these generic system barriers have been encountered in some vanguard sites.

Of greater interest here, we also found other barriers relating more specifically to the inclusion of mental health in new models of care. Mental health leaders involved in our research expressed the need to be physically present at all relevant meetings to keep mental health firmly on the new care model agenda, even where it had been identified as a strategic priority for the vanguard. In the words of one vanguard leader, 'people know it's important but operationalisation is challenging'. In this context, tokenism is an ever-present danger – the risk being that references to mental health are included in strategic documents, but without a clear plan for delivering these ambitions.

The expectation from policy-makers that vanguard sites will provide rapid answers to the current pressures in the health system, and the consequent focus of new care models on groups who use most resources in the here-and-now (often older people with frailty), appears to have sometimes steered strategic thinking away from addressing needs relating to mental health. Some of the leaders involved in our research felt that because of the pressure to demonstrate in-year savings, there had been insufficient space to develop innovative approaches to mental health care. This

illustrates the difficulty of trying to achieve transformation within available resources, even with the additional funding that vanguard status has delivered.

The situation was not helped by the financial settlement received by vanguard sites in 2016/17 and 2017/18. In some areas, some of the mental health components included in original vanguard plans had been scaled back or cancelled because national funding was less than expected (it should be noted that this experience was not limited to mental health components alone). Furthermore, we found that the non-recurrent nature of vanguard funding was seen as a significant barrier in some areas.

As with other parts of the health and care system, mental health services in England are currently operating under extreme pressure as a result of ongoing financial stringency, rising demand and workforce shortages (Gilburt 2016b, 2015). Some mental health professionals expressed concern that in this context, an increasing focus on integrated working (for example, embedding mental health staff in integrated care teams or working more closely with primary care) could involve resources being diverted away from specialist services for people with severe mental illnesses. In the longer term, it is possible that by responding earlier and more effectively to emerging mental health needs, integrated working could reduce pressure on other mental health services (and indeed on wider health and care services). However, in the interim, it is important to ensure that investment in integrated working does not deplete much-needed resources for core mental health provision. Further research is needed to identify the specific components that are needed if integrated approaches to mental health are to help alleviate pressures elsewhere in the system, and to clarify the timescales over which this can happen.

Opportunities ahead

Previous publications have discussed the potential benefits of developing more integrated approaches to mental health at all levels of the health system, from prevention to acute hospital care (Naylor *et al* 2016; Royal College of Psychiatrists 2013). If these opportunities have not yet been realised in full, what should the next steps be? One way to answer this question is to focus on the four levels of the MCP and PACS care models (*see* section 4), which provide a description of the main areas where it is intended they will bring about improvements. There are substantial opportunities to make further progress at each of these levels (as described below).

- **Complex needs:** Ensuring that local integrated care teams are able to make full use of mental health expertise in supporting people with complex and ongoing care needs, with mental health staff able to input proactively into all case discussions and offer advice and training to the wider team.
- **Long-term care needs:** Making new forms of mental health support a central component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice (including among people presenting primarily with physical symptoms), and also to address the physical health needs of people with long-term mental health problems. This will need to be done in a way that is aligned with wider efforts to transform primary care to ensure that it is sustainable for the future (*see* box, p 47).
- **Urgent care needs:** Strengthening mental health components of urgent and emergency care pathways. Again, this should include appropriate mental health support for people presenting with physical health symptoms as well as those experiencing mental health crises.
- **Whole-population health:** Incorporating a focus on public mental health and wellbeing within population health management approaches, recognising the role of poor mental health as a major risk factor for many other conditions. This should include work on perinatal mental health, children and young people (where some of the greatest opportunities for prevention lie), and also on wider services such as drug and alcohol, homelessness or housing services and employment support.

Further evidence will be needed to guide action at each of these levels. As such, local and national evaluations of new models of care should include an assessment of their impact on people with mental health problems as well as on mental health and wellbeing-related outcomes across the wider population. It will also be important to assess how the mental health components of the new models of care have contributed to wider health and social outcomes. The 'learning and impact studies' to be conducted as part of the evaluation strategy provide one potential means of testing the mental health components of the models (Tallack 2017).

Learning from the vanguard sites should be combined with existing evidence about good practice. Many of the service models recommended in the Forward View for

Mental Health are supported by a considerable evidence base, and implementing these tried-and-tested models should proceed in parallel with attempts to integrate mental health into new models of care. There may also be relevant learning to draw on from other national programmes – for example, from areas that are currently piloting new approaches to child and adolescent mental health and secure care services (NHS England 2014).

As new models of care are developed in other areas beyond the vanguard sites, two things will need to be done to ensure that the opportunities relating to mental health are not missed. First, testing the mental health components of existing vanguard sites must be a central part of the evaluation strategy for new care models, as already argued. Second, looking beyond the vanguard sites, local areas rolling out an MCP or PACS model should aim to go further than the vanguards in the four areas listed above. To support this, we would again highlight the importance of including mental health from the initial design stages of new models of care, rather than as an adjunct.

Mental health and enhanced models of primary care

Transforming primary care is a major priority in many parts of the country. The extreme pressures being experienced in general practice make it clear that primary care services are not sustainable in their current form, and that substantial changes to models of general practice are now inevitable (Baird *et al* 2016). The proposals in the GP Forward View build on the ongoing trend of GPs joining with other professionals in practice groups, federations and a variety of other models (NHS England 2016a). As local system leaders think about how to transform primary care, it is important that new approaches to mental health care are integral to their plans, given the high levels of unmet or poorly met mental health care needs among people using GP services, and the impact of this on patients and staff alike.

The 3,000 additional primary care mental health workers announced in the GP Forward View may play a part in this, but further detail is needed on where these workers will come from and what roles they will perform. The expansion of the physician associate workforce also potentially creates an opportunity to deliver more integrated mental health in primary care and elsewhere. The educational curriculum for physician associates currently includes limited coverage of mental health, so additional training may be required for these professionals to support integrated working.

The policy intention is that most of England's population will be covered by MCPs, PACS or similar care models within the next few years, with STPs being seen as the primary vehicle for rollout. Concerns have been raised that some STPs include only limited content on mental health and are not well aligned with the national ambitions laid out in the Forward View for Mental Health and elsewhere (Gammie 2016; Naylor 2016). It is vital that STP leaders are encouraged to make mental health a central part of their plans, and that they are able to take heed of the emerging lessons from vanguard sites. Data packs recently commissioned by NHS England may help STP leaders in selecting areas to focus on, but there will need to be additional support in terms of designing and implementing the care models that flow from this (Gammie 2017).

In the longer term, several parts of the country are seeing MCP and PACS models as a staging post on the way to building accountable care organisations or systems, with NHS England and NHS Improvement providing support to a number of areas exploring these approaches (NHS England 2017). This would involve: developing a single capitated budget for a broad range of services (potentially including mental and physical health care); building a single provider or partnership capable of holding that budget; and shifting the focus of commissioners towards measuring high-level, longer-term outcomes (Collins 2016). There are potential opportunities in these types of reform for integrated providers to choose to invest resources in mental health care in order to improve broad population health outcomes and to deliver better value across the wider system (the box below provides indicative evidence about the scope to deliver better value by doing so). It is important that mental health providers ensure they are active partners in the development of accountable care systems and organisations if these opportunities are to be realised.

Can integrated approaches to mental health deliver better value?

In primary care

- Integration of mental health into primary care teams in Intermountain Healthcare, an integrated health system in the United States, was associated with lower use of some forms of acute care and reduced costs in real terms across the system (Reiss-Brennan *et al* 2016).
- An evaluation of an integrated mental health service in GP practices for people with persistent physical symptoms and other complex needs in City and Hackney (London) found that over a follow-up period of 22 months, around a third of the costs of providing the service were offset by savings from reduced service use in primary and secondary care (Parsonage *et al* 2014).

In long-term conditions management

- In a research trial in the UK, integrating mental health support into cancer care pathways using the collaborative care model improved mental health outcomes, reduced pain and fatigue, and improved general functioning and quality of life (Sharpe *et al* 2014) and was found to be highly cost effective (Duarte *et al* 2015).
- Introduction of the 'three dimensions for diabetes' (3DfD) service in south London, which included integrated support for mental and social needs, was associated with improved control of blood glucose levels among the people served, reduced emergency attendances and reduced diabetes complications. In an economic evaluation, the financial value of reduced hospital activity was found to be 35 per cent higher than the costs of delivering the 3DfD service (Ismail and Gayle 2016).
- Including a psychological component in a breathlessness clinic for COPD in Hillingdon Hospital led to fewer A&E presentations and hospital bed days during the six months after the intervention (Howard *et al* 2010). This translated into savings of around four times the upfront costs of the intervention.

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Can integrated approaches to mental health deliver better value?
continued

In acute hospitals

- In the Greater Nottingham urgent and emergency care vanguard, strengthening the mental health liaison team in A&E in line with the 'core 24' service standard is reported to have led to a 3 per cent improvement in the acute trust's overall performance against the four-hour wait target.
- An evaluation of the Rapid Assessment Interface and Discharge (RAID) service in Birmingham found that on conservative assumptions, benefits in terms of reduced inpatient bed use within the acute hospital exceeded the costs of the service by a factor of more than four to one (Parsonage and Fossey 2011).

7 Recommendations

Recommendations for local system leaders

- Ensure that mental health is a core component of all work on new models of care, including in MCPs, PACS, acute care collaborations, urgent and emergency care networks and primary care homes, using the nine design principles and emerging lessons in this report as a guide.
- Integrate mental health at all levels across the new care model and avoid seeing mental health as a separate work stream.
- Include mental health expertise in the central programme management team responsible for overseeing the implementation of a new model of care.
- Ensure that new models of care address outcomes that are important to patients, service users and carers, as well as outcomes that are desirable for the system. In order to achieve this, involve patients, service users and carers early in the design process.
- Strengthen mental health capabilities in the primary and community health workforce by improving the confidence, competence and skills of GPs, integrated care teams and others. Similarly, aim to strengthen the physical health competencies of mental health professionals.
- Ensure that professionals involved in new models of care have protected time to provide an educational function to other members of staff, in order to share learning between health professionals working in physical and mental health.
- Include mental health metrics in local evaluations of new models of care that reflect outcomes, activity and quality of provision.

Recommendations for NHS England

- Ensure that the national evaluation of the new care models programme captures the impact these models have had on people living with mental health problems, the impact on mental health and wellbeing-related outcomes across the wider population, and an assessment of how the mental health components of new models of care have contributed to wider health and social outcomes. The learning and impact studies conducted as part of the evaluation strategy should include a focus on mental health components of integrated care.
- Provide local systems with guidance and examples of good practice, demonstrating how mental health support can be successfully embedded in integrated care teams, enhanced models of general practice, and urgent and emergency care pathways.
- Ensure that local health systems receiving national funding for large-scale transformation programmes are required to go above and beyond national mental health policy expectations or to do so at an accelerated pace, to ensure that such work is consistent with the commitment to parity of esteem.
- Hold local system leaders to account for including the development of integrated approaches to mental health in STPs, and for implementing these effectively. We recommend that only STP footprints that have articulated a clear ambition for this should be supported to roll out a new contractual model, such as an MCP, PACS or care homes contract.
- Work with Health Education England to ensure that workforce development needs in relation to mental health identified in the vanguard sites inform wider strategic thinking on education, training and continuing professional development.

Appendix A: Further resources

National mental health policy resources

- Mental health access and waiting time standards www.england.nhs.uk/mental-health/resources/access-waiting-time/
- *Delivering the five year forward view for mental health: developing quality and outcomes measures* www.england.nhs.uk/mental-health/resources/
- New payment approaches for mental health services https://improvement.nhs.uk/resources/new-payment-approaches/

Resources for vanguard and STP leaders

- NHS England's STP aide-mémoire: mental health and dementia www.england.nhs.uk/stps/support/
- 'Where to look' packs for STP footprint areas www.england.nhs.uk/rightcare/intel/cfv/stp-footprints/
- Identifying and addressing the physical health needs of mental health service users: data packs for STPs, forthcoming, NHS England
- *The Forward View into action: new care models: support for the vanguards* www.england.nhs.uk/ourwork/new-care-models/vanguards/support/
- *Evaluation strategy for new care model vanguards* www.england.nhs.uk/2016/05/ncm-evaluation-strategy/
- *The multispecialty community provider (MCP) emerging care model and contract framework* www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/
- *Integrated primary and acute care systems (PACS) – describing the care model and the business model* www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/primary-acute-sites/

- *The framework for enhanced health in care homes* www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/care-homes-sites/
- *Bringing together physical and mental health: a new frontier for integrated care* www.kingsfund.org.uk/publications/physical-and-mental-health

Resources for CCGs

- CCG Commissioning for Value 'Where to look' packs www.england.nhs.uk/rightcare/intel/cfv/stp-footprints/
- Commissioning for Value tools http://ccgtools.england.nhs.uk/cfv2016/mh/atlas.html
- *Guidance for commissioning public mental health services* www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/
- *Guidance for commissioners of primary mental health care services* www.jcpmh.info/good-services/primary-mental-health-services/
- *Modelling the interface between primary care and specialist mental health services: a tool for commissioning* www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/research/interfacestudy.aspx
- *Guidance for commissioners of services for people with medically unexplained symptoms* www.jcpmh.info/good-services/medically-unexplained-symptoms/
- *Access and waiting time standard for children and young people with an eating disorder: commissioning guide* www.england.nhs.uk/2015/08/cyp-mh-prog-launch/
- *Guidance for commissioners of liaison mental health services to acute hospitals* www.jcpmh.info/good-services/liaison-mental-health-services/
- *Guidance for commissioners of drug and alcohol services* www.jcpmh.info/good-services/drug-and-alcohol-services/
- *Guidance for commissioners of rehabilitation services for people with complex mental health needs* www.jcpmh.info/resource/guidance-for-commissioners-of-rehabilitation-services-for-people-with-complex-mental-health-needs/

- *Guidance for commissioners of mental health services for people with learning disabilities* www.jcpmh.info/good-services/learning-disabilities-services/
- *Improving the physical health of adults with severe mental illness: essential actions* www.rcpsych.ac.uk/mediacentre/adultswithsmi.aspx
- *Improving the physical health of patients with serious mental illness: a practical toolkit* www.england.nhs.uk/mental-health/resources/smi-toolkit/
- *Guidance for commissioners of financially, environmentally, and socially sustainable mental health services (future proofing services)* www.jcpmh.info/good-services/sustainable-services/

Appendix B: Case study site profiles

Case study 1: Happy, Healthy, at Home PACS North East Hampshire and Farnham

Overview

The Happy, Healthy, at Home vanguard is an integrated PACS, serving a population of 220,000 across North East Hampshire and Farnham (*see* Figure B1 for key components). A number of organisations and partners are involved, including:

- NHS North East Hampshire and Farnham CCG
- Frimley Health NHS Foundation Trust (an acute trust)
- Southern Health NHS Foundation Trust (a community and mental health trust)
- Surrey and Borders Partnership NHS Foundation Trust (a mental health and learning disabilities trust)
- South East Coast Ambulance Service NHS Foundation Trust
- North Hampshire Urgent Care
- Hampshire County Council
- Surrey County Council
- local third sector organisations
- the local population, including patients, service users and carers.

Figure B1 **Key components of the Happy, Healthy, at Home PACS**

The vanguard is described as 'an integrated health, social care and wellbeing system', which aims to 'put prevention at the centre of everything [they] do'. It involves three broad work streams, outlined below.

1. Acute work stream

This includes work to improve access in and out of specialist inpatient care. Elements include: GPs working on wards at Frimley Park Hospital to support and facilitate discharge; GPs based in Frimley Park A&E; the introduction of 'EMIS viewer', allowing staff in A&E and out-of-hours services to view GP records; and work to enhance out-of-hours services and improve triage.

2. Community work stream

This includes: the development of integrated teams of health and social care professionals (including mental health professionals) working to deliver and co-ordinate care in the community; and the development of a new recovery,

rehabilitation and re-ablement service, which aims to prevent hospital admissions and enable earlier discharge by bringing together services provided by the community trust, the acute trust and the local authority.

3. Prevention work stream

This includes: a Recovery College offering support for people living with, or recovering from, chronic mental or physical health conditions; mental health crisis support through the introduction of Safe Havens; social prescribing, including the Making Connections programme, which connects people with local resources and voluntary sector services; and carers' support networks. These elements of the vanguard work are described in detail below.

Work related to mental health

Integrated care teams

Integrated care teams are a key aspect of the vanguard work in North East Hampshire and Farnham. They are locality-based, multidisciplinary teams that work with individuals with complex care needs, including older people living with frailty, people living with long-term conditions or multiple co-morbidities, and people approaching the end of life. They are able to address complex needs by drawing on a variety of expertise, and co-ordinate care from different professionals and services. Team members include: community nurses, occupational therapists, physiotherapists, social workers, pharmacists, mental health practitioners, geriatricians, GPs, voluntary sector workers and team co-ordinators. There are five teams, each covering one locality area. The teams are based in the community, and deliver care to people in their own homes.

Referrals commonly come from GPs, community nurses and hospital staff. Information from the ambulance service and A&E enables the team to identify individuals at risk of hospital admission or at other crisis points who may benefit from their involvement. All individuals referred are required to give their consent to be discussed.

During regular team meetings, all cases under the team and any new referrals are discussed. Depending on their needs, referrals are then directed to the most appropriate professional(s) within the team for assessment and management, but will continue to be discussed regularly by the full team.

Three mental health practitioners (two band 7 nurses and one occupational therapist) work across the five teams. Their main role is to work with adults with co-morbid physical and mental health conditions, particularly when an underlying mental health problem is affecting an individual's engagement or their ability to self-manage. The mental health practitioners have monthly clinical supervision with a consultant psychiatrist, who they can contact for advice or guidance if required. Current plans are to increase the number of mental health practitioners to one band 7 practitioner per team, all also receiving supervision from a clinical psychologist.

The teams work closely with GPs, and mental health practitioners have an important role in supporting primary care professionals to manage mental health issues and understand the interaction between physical and mental health.

Recovery College

The Recovery College offers educational courses and workshops to help people improve their own health and wellbeing, and is run in partnership with the mental health trust, voluntary sector and local authority.

The college was originally developed for individuals living with personality disorder, and was largely focused on mental health and wellbeing. Following a successful pilot phase, the college was included within the vanguard, and was significantly expanded as a result. Courses are now open to a wide range of participants, including service users, carers and professionals. There is no separation in terms of which courses people can attend, and it is increasingly common for a class to include service users, carers and professionals. Individuals can be referred or may self-refer. Courses are delivered in community locations such as libraries and community centres.

The vanguard has expanded the remit of the college to focus on both mental and physical health, and there is a dedicated course exploring the links between the two. It now offers more than 30 courses covering a wide range of topics, including: health and wellbeing; understanding; skills and creativity (a full list can be found in the prospectus on the Recovery College website). Work is ongoing to further develop the offer, particularly to enhance the focus on physical health, wellbeing and prevention.

The Recovery College was co-designed with service users, carers and staff, and this ethos of service user involvement has continued throughout its development. All courses are co-produced by individuals with relevant lived experience, and most are also co-delivered. Individuals involved in delivering courses receive training, supervision and support. Service users and carers are able to volunteer to support the work of the college – for example, through assisting with transport, administration and course design and delivery. A number of individuals with lived experience are employed by the trust as recovery coaches or senior recovery coaches.

Safe Haven

Introduced as a short-term pilot in 2014, the Safe Haven was set up to offer out-of-hours mental health crisis support and an alternative to A&E. Although the project predates the vanguard, it has been significantly expanded as a result. There are now six Safe Havens based in town centre locations across Surrey and North East Hampshire. The service is provided by a partnership between the mental health trust and third sector.

Each Safe Haven is staffed by a qualified mental health practitioner from the mental health trust, and two trained staff from third sector providers. Peer support from people with lived experience is also encouraged and increasingly available.

The Safe Haven model is open access, and does not require referral or a prior appointment. In addition to offering direct support to individuals experiencing a mental health crisis, the Safe Haven team are able to access home treatment or inpatient services if necessary. The Safe Havens also work closely with police and ambulance services to prevent unnecessary A&E attendances, and with A&E liaison to identify people attending A&E who could benefit from the Safe Haven, linking them into the service.

As in the case of the Recovery College, there was a strong emphasis on service user engagement and co-design during development of the model.

Social prescribing

The vanguard has developed a programme called Making Connections, with dedicated Making Connections workers (a new role delivered through the voluntary sector) in GP surgeries. These individuals act as navigators, connecting people to local resources and helping them to identify and access community services that

may improve their health and wellbeing. This enhances the non-clinical support available to patients and service users, and provides GPs and professionals in the integrated care teams with an additional type of support to offer.

Carers' support network

In addition to focusing on patients and service users, much of the vanguard work also includes a focus on the needs and wellbeing of informal carers. Programmes such as the Recovery College and Safe Haven can be accessed by carers, and work is also under way to develop a carers' support network. This has included the development of carers' hubs offering advice, signposting and support, and carers' engagement events run in partnership with the local Healthwatch and The Princess Royal Trust for Carers.

IAPT expansion

North East Hampshire and Farnham is one of 22 areas being supported by NHS England to expand IAPT. These 'early implementer' projects are intended to lead the way in integrating psychological therapies with physical health care.

Care pathways in North East Hampshire and Farnham include a pathway for persistent physical symptoms in which therapists work with GPs and patients who frequently attend primary and urgent care services; there is also a pathway for COPD, which offers integrated working with pulmonary rehabilitation teams, house-bound working and psycho-educational courses. Pathways are also under development for cardiovascular disease and perinatal care.

While this does not directly fall under the vanguard work streams, it is viewed locally as being part of the same drive to bring together mental and physical health pathways. Progress achieved through the vanguard has facilitated the integration and co-location of mental health services with primary care, which will be further developed through IAPT expansion.

Outcomes

There is limited outcomes data available so far for some elements of the work – for example, there is no comprehensive data on outcomes of the integrated care teams (a core element of the model). However, early data is available for some elements, particularly for the Recovery College and Safe Havens, as follows.

- A provisional evaluation of the Safe Havens found excellent service user feedback, a 33 per cent reduction in admissions to acute inpatient psychiatric beds and a plateau in A&E attendances for mental health issues (in contrast to continuing growth in attendances from surrounding CCGs).
- Early data from the Recovery College (from pre- and post-course questionnaires) shows improvements in process of recovery (QPR) scores and reductions in GP visits, A&E attendances and police contacts. This questionnaire data also shows reductions in contacts with home treatment teams, psychiatric liaison teams, crisis lines and the Safe Havens.

More extensive evaluation of all aspects of the work is ongoing.

The additional mental health support these schemes provide has been welcomed by professionals. The mental health expertise embedded in the integrated care teams has been particularly well received by GPs, district nurses and others, who can not only refer patients on but are also able to obtain advice and guidance directly from the mental health practitioners. There has also been positive feedback from other services – for example, from police and ambulance services regarding Safe Havens.

Much of this work is continuing to develop, and early indications from the Frimley STP suggest that aspects of the vanguard are likely to be scaled up across the footprint.

Key enablers

- The vanguard work has built on longstanding existing relationships (for example, between the mental health trust and the CCG, and between the mental health and acute trusts). Other relationships that were previously less well developed – for example, with the local authority and third sector organisations – have been strengthened through the work.
- The strong emphasis on mental health and wellbeing in much of the vanguard work has been facilitated through involvement of mental health representatives at all levels, including in key senior positions. Strong mental health leadership has been a key driver of the progress made.

- Many aspects of the vanguard work, particularly the Safe Haven and Recovery College models, have benefited from a strong emphasis on service user involvement and co-design.
- For some aspects of the work, a focus on measuring early outcomes has helped to gain support and traction; early evaluations of the Safe Havens and Recovery College have been important in building the case for expanding and spreading the models.

Further information

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Case study 2: Tower Hamlets Together MCP

Overview

Tower Hamlets Together is an MCP vanguard serving a population of 287,000. It aims to deliver innovative, integrated and seamless care to patients, carers and families across the borough. Partners include: Tower Hamlets GP Care Group, Tower Hamlets Clinical Commissioning Group, Barts Health NHS Trust, East London NHS Foundation Trust, the London Borough of Tower Hamlets, and the Tower Hamlets Council for Voluntary Service.

People living in Tower Hamlets face significant health inequalities, with the highest rate of child poverty in England and the second highest premature death rate (of all the London boroughs) among adults from circulatory disease, cancer and respiratory disease. People in Tower Hamlets also have the lowest healthy life expectancy in England and develop co-morbid long-term conditions earlier in life. To address some of these issues, Tower Hamlets Together has embarked on an ambitious transformation programme that focuses on three priority areas:

- improving care for adults with long-term conditions or complex needs
- developing a population-wide health programme that focuses on prevention
- developing a new model of integrated care for children and young people.

Across the Tower Hamlets borough, 36 primary care practices are organised into eight networks, which are then aggregated into four localities.

The vanguard programme is overseen by the Tower Hamlets Together board, which is responsible for co-ordinating the development of new governance arrangements with the CCG. The board will have two operational committees that oversee system management and quality, and four transformation programme boards.

Work related to mental health

The programme includes various pieces of work relating to mental health, which are at different stages of development. Arguably, the most advanced work around mental health is focused on the Integrated Care Programme. It is aimed at: people with the highest care needs through co-ordinated community-based and inpatient care; those with ongoing care needs through enhanced primary and community care; and those with urgent care needs through integrated access and rapid response functions.

In the description that follows, we have included a number of components that were initially established before the vanguard but which local leaders argue are an indispensable part of an effective MCP.

Priority 1: Integrated care for adults with complex needs

In response to this vanguard priority, Tower Hamlets Together has developed integrated community health teams, a primary care mental health service, and expanded its liaison psychiatry service in the local acute hospital.

Integrated community health teams

Tower Hamlets Together has developed four integrated community health teams with the purpose of delivering enhanced care for people with complex and ongoing needs in the community. This service is open to adults who are on the primary care registers for dementia, palliative care or care homes, along with people who would benefit from a multidisciplinary approach.

The four integrated community health teams serve a total of eight networks across the borough and include: community mental health nurses; district nurses; allied health professionals; pharmacists; social support workers; and community matrons. In terms of the mental health expertise within these teams, there are four

whole-time equivalent (WTE) senior mental health nurses (band 7) in each locality, with experience of working in mental health services for adults, older adults and supporting people with drug and/or alcohol issues. These mental health nurses are supported by a 0.5 WTE consultant psychiatrist, who also works with two WTE mental health occupational therapists to support care homes in the borough to deliver person-centred care for people with dementia.

Mental health nurses within the integrated community health teams attend practice-based multidisciplinary team meetings to help identify patients who potentially have a mental health problem that may be complicating their presenting illness. They also provide brief treatment where patients require additional support but do not warrant a referral to secondary care.

In addition to the above, mental health nurses provide consultation and training to community health teams and primary care professionals to improve their knowledge on mental health. The curriculum for this is under development. Separate but related to this, these teams also aim to support clinically appropriate discharge of patients who have serious mental illnesses from secondary mental health services into primary mental health services.

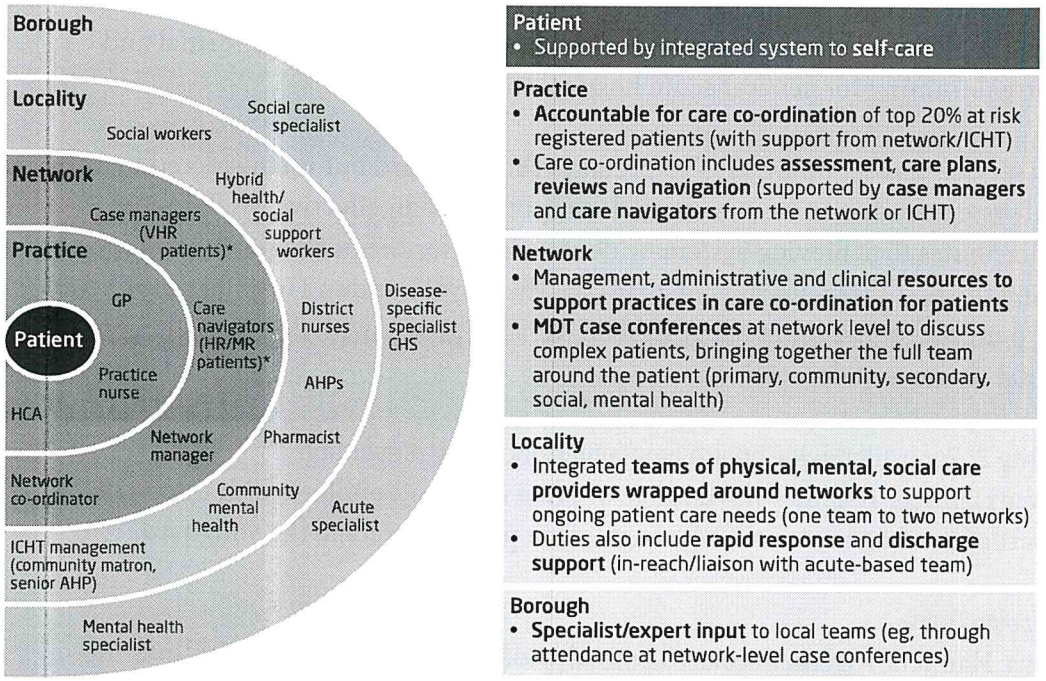
Primary care mental health service

Tower Hamlets Together MCP, working with partners from City and Hackney and Newham, has developed a primary care mental health service to support the discharge of people with stable serious mental illness into recovery-oriented primary care services, and provide step-up support to people from primary care (*see* Figure B2). Since the scheme's inception in 2013, more than 5,000 people have received support from the primary care mental health service in east London, helping to create a smaller but more responsive secondary care service and improve patient and practice experience.

The service includes a contract with practices to provide additional practice-based support for service users with a focus on healthy lifestyles, along with a team of primary care-based mental health professionals providing recovery-oriented support. An integral part of the model is the significant improvement in communication between secondary and primary care that the service has brought about, with regular practice-based multidisciplinary teams attended by secondary care consultant psychiatrists. Figure B2 illustrates this in more depth.

Figure B2 Care co-ordination model in Tower Hamlets

Tower Hamlets has developed a localised vision for an integrated care system wrapped around patients and primary care



Intensity of patient care co-ordination depends on risk of readmission

* Case managers (clinical/social)/care navigators (administrative) could be employed at network or locality level. These functions could be provided by aligning existing staff in primary/CHS/social care, with additional recruitment if required.

Source: adapted from Towers Hamlets Together 2016

Psychological medicine in acute hospitals

The Department of Psychological Medicine provides a mental health liaison service to people of all ages (16+) in Tower Hamlets, based on the RAID model. The service provides mental health assessment to patients who attend the A&E department and to inpatients at The Royal London Hospital, Mile End Hospital or the London Chest Hospital. The service is available 24/7, with a target of assessing referred patients who present to A&E within one hour and assessing referred patients on inpatient wards within 24 hours.

The multidisciplinary team combines expertise in adult and older people's mental health to provide assessment, treatment and management of mental health problems, including anxiety, depression, dementia, schizophrenia, and any other mental health or psychological problem in a ward setting or in the A&E department (including specialist alcohol and drug support). The team also provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff.

This service was set up in 2014 so predates the vanguard but is considered by local system leaders to be an essential component of an effective MCP model as it contributes to achieving system-wide outcomes for the borough. For instance, during the first three quarters of 2016/17, The Royal London Hospital reported a 12.7 per cent reduction in occupied bed days for people with dementia, serious mental illness and depression.

Priority 2: Population-wide health programme, including prevention

Tower Hamlets Together has a range of preventive and public health interventions as part of its vanguard work, although some projects predate the vanguard.

Wellbeing Hubs

Tower Hamlets Together seeks to embed wider determinants of health into the new model of care. The majority of people (80 per cent) living in the borough are considered to be at a low risk or very low risk of admission to hospital (224,000 people). For this group, plans have focused on population health management models and targeting people with risky lifestyle factors.

Tower Hamlets has established four Wellbeing Hubs where people can access information on a range of resources available in the local community. Through a '360-degree' social care assessment, people may be referred to: lifestyle services, including health trainers; an Integrated Employment Hub; recovery and wellbeing services; or to the single point of access. Similarly, through patient activation, people can self-manage their own condition better, drawing on support from health outreach workers for information and signposting, volunteers for additional support to help access services, and a social prescribing service.

It is expected that the hubs will hold detailed information on mental health provision within the borough and, where appropriate, people will be signposted to such services and support mechanisms. Likewise, mental health services, where appropriate, will be able to signpost their clients to hubs for support in addressing their wider needs within the community.

Community Recovery and Wellbeing service

A Community Recovery and Wellbeing service was commissioned by the CCG in June 2016, through a combination of CCG and council funding, to a consortium of organisations called INSPIRE. This service aims to support people with low-level mental health issues that would not warrant a referral to specialist services. The team provide one-to-one interventions and support in the community, including peer support and signposting to relevant services or groups.

Furthermore, people living with severe and enduring mental health problems can access courses offered by the Recovery College, which aims to support people to work towards achieving meaningful, self-defined recovery. Again, this service predates the vanguard but forms an important component of support available for those with ongoing health needs.

Making Every Contact Count

The Making Every Contact Count (MECC) initiative aims to encourage those who work with the public to make the most of every opportunity to have a conversation about a healthy lifestyle and offer signposting information to facilitate behaviour change.

In Tower Hamlets, frontline staff receive training on how to pick up on conversational cues about staying healthy that someone may be willing to discuss further, and how to encourage them to act. Through MECC, one of the conversations that staff are encouraged to discuss is 'five ways to wellbeing', to support people to consider their mental health and wellbeing. The other lifestyle factors that are included in the MECC approach (such as physical activity and healthy eating) will also have some positive impact on mental wellbeing.

Priority 3: A new model of integrated care for children and young people

Universal preventive services for children and parents

Across Tower Hamlets, the ambition is to reduce the number of children who need social care services and to improve their education outcomes. Through the vanguard work, Tower Hamlets Together is integrating universal health services so that health visiting, midwifery and school health is joined up with local authority services, children's centres and education services. This includes a focus on emotional wellbeing and targeted support where necessary. Examples include:

- the existing Five to Thrive programme increasing its focus on emotional wellbeing among people who use the service
- the existing portage service (a home-visiting educational service for pre-school children with additional support needs and their families) being expanded to children's centres.

Integrated health services for children and young people

Similar to the model adopted for adults, Tower Hamlets Together is now reorganising services for children and young people so that care is provided in a more integrated way. Children's health services have previously been managed by individual specialist areas, and the model will see integrated multidisciplinary working across children's health services. The plan is for services to integrate with child and adolescent mental health services.

Outcomes

- Since 2014/15, Tower Hamlets MCP has seen a 2.2 per cent fall in emergency admissions, compared to 2.7 per cent growth for all other MCP vanguards and 3.3 per cent growth for non-vanguard CCGs. Furthermore, there has been 3.7 per cent reduction in occupied bed days, compared to 1.9 per cent for non-vanguards.
- Since its inception in 2013, more than 5,000 people have accessed the primary care mental health service. This has helped to create a smaller, leaner but more responsive secondary care service and improve patient and practice experience at the same time.

- In 2016/17 there was a statistically significant 12.7 per cent reduction in occupied bed days for people with depression, serious mental illness and dementia, while rates of emergency admissions have remained static.
- As described on p 33, Tower Hamlets partners are currently developing a system-wide outcomes framework that defines the partners' collective ambition to improve outcomes for people who live in the borough. It is anticipated that they will monitor performance against this framework during 2017/18.

Key enablers

- In Tower Hamlets, the vanguard work around mental health has been built on several existing initiatives. In 2012, the Integrated Pioneer programme across Tower Hamlets, Waltham Forest and Newham CCGs allowed them to introduce nine high-impact interventions across the three boroughs. Two of these interventions focused on mental health initiatives: the development of a fully compliant 'core 24' RAID service and a primary care mental health service. The vanguard programme has enabled the partners to expand their transformation programme within an accelerated timeframe.
- Creating a shared ambition through the vanguard has helped partners align their own organisational plans for health and social care services and to focus on objectives for the whole system.
- East London NHS Foundation Trust is a full partner in the vanguard, which was considered to be an enabling factor for driving improvements in mental health integration.
- The foundation trust recruited a public health lead to support the development of more integrated mental/physical health and preventive pathways in the context of the vanguard, working with the Tower Hamlets vanguard public health consultant.
- Tower Hamlets has aligned incentives and reimbursement models to encourage integrated care across the system. Provider partners have been working together to deliver against a shared local incentive scheme since 2016/17. This scheme places provider income at risk and makes available a potential £1 million benefit to providers, dependent on the delivery of 10 outcome goals over the course of the year. Two of these are related to mental health:

emergency readmissions for people with depression, serious mental illness or dementia; and total bed days for the same groups.

- The use of a capitation-linked dataset to understand patterns of primary care, acute and social care utilisation by people with mental health problems has enabled system leaders to understand the financial and quality opportunities of new pathways across mental and physical health.
- Tower Hamlets is working with Newham and Waltham Forest CCGs and UCL Partners to develop a multidisciplinary team concordat that aims to support the team to work more effectively together, with a focus on having the right discussions, with the right people, targeting the right patients.

Further information

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http://towerhamletstogether.weebly.com/

Case study 3: West Cheshire Way MCP

Overview

West Cheshire Way is an MCP serving a population of 260,000. Partners include:

- Primary Care Cheshire (a federation of all 35 local practices)
- NHS West Cheshire Clinical Commissioning Group
- Cheshire and Wirral Partnership NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- Cheshire West and Chester Council
- voluntary sector and community groups.

Cheshire and Wirral Partnership NHS Foundation Trust is the main provider of mental health services in the area covered by the vanguard, and also provides community services for physical health. The vanguard programme is structured around three life-course stages:

- starting well
- working well
- ageing well.

At the core of the model being developed is nine integrated care teams, each working with a cluster of GP practices and serving a population of around 30,000. These teams bring together professionals from health, social care and the voluntary sector, including:

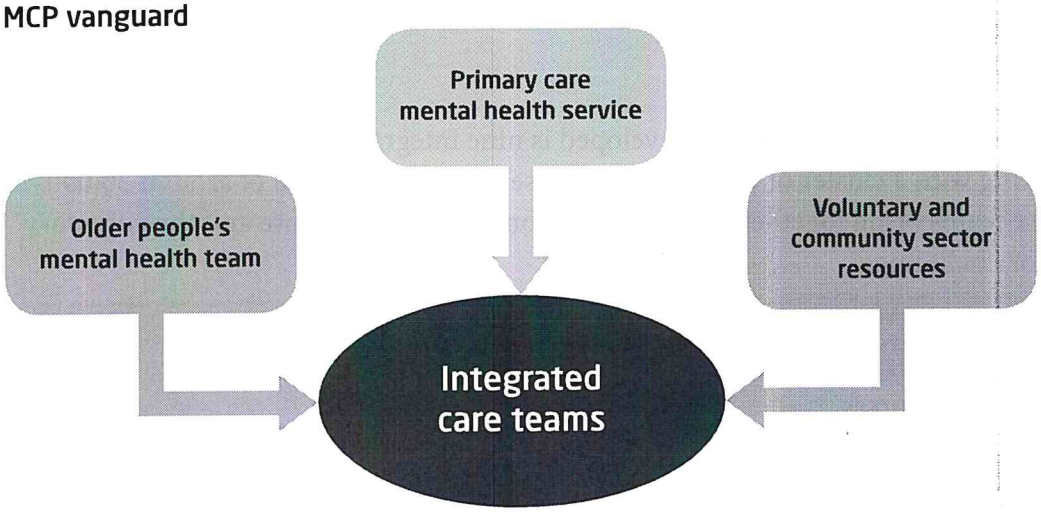
- community nurses
- district nurses
- a community matron
- speech and language therapists
- occupational therapists
- physiotherapists
- social workers
- wellbeing co-ordinators.

The integrated care teams support patients with highly complex needs who are generally housebound and often frail. People over the age of 65 account for around 75 per cent of the caseload, the remainder being younger adults with multiple conditions or people in need of intensive post-operative care at home. The teams accept referrals from GPs and hospital wards, and hold monthly multidisciplinary team meetings with each GP practice served.

A distinctive aspect of the approach taken in West Cheshire is the emphasis placed on helping people to stay well in a broad sense – physically and mentally. This includes a focus on connecting integrated care teams with resources in the voluntary and community sector, using wellbeing co-ordinators employed by Age UK.

Figure B3 illustrates three ways in which the integrated care teams secure expertise and support for people with mental health needs. These are elaborated on in the remainder of this section.

Figure B3 **Mental health inputs into integrated care teams in West Cheshire Way MCP vanguard**



Work related to mental health

Linking integrated care teams with specialist mental health services

Rather than being fully embedded in the integrated care teams, mental health professionals work in close liaison with the teams. Two main sources of support are available – the older people's mental health team, and the primary care mental health service.

For adults over the age of 65, there is a close connection with the older people's mental health team. The nine integrated care teams are arranged into three localities and each locality is supported by a designated band 7 community psychiatric nurse in the older people's mental health team. Members of the integrated care team can contact their named clinical lead by phone for advice, and they may be invited to attend a case discussion in a multidisciplinary team meeting. The support offered includes help with dementia diagnosis, managing challenging behaviours, assessment of capacity, and helping to navigate pathways into specialist mental health services.

A new older people's consultant psychiatrist post has also been created to provide additional educational input into the integrated care teams and primary care (the post involves doing this half-time and working half-time in the older people's mental health team). Each integrated care team takes part in three educational

sessions per year, covering topics such as challenging behaviours, cognitive assessment, the role of memory clinics, dementia, mood, capacity, case discussions, and any specific areas requested by the team.

For adults below the age of 65, each of the integrated care teams has a link worker in the primary care mental health service (*see* below). Through this arrangement, staff in the primary care service are able to provide psychological management and support for people with long-term conditions being seen by the integrated care team. This means that the integrated care teams have access to mental health support for people of working age as well as older adults. This has resulted in more psychological input into a number of care pathways (for example, mental health nurses and psychologists provide input into diabetes clinics and the cardiac rehabilitation programme).

At present, mental health professionals are only invited to attend an integrated care team's multidisciplinary team meeting to discuss specific cases. However, the plan for the future is to let the relevant mental health teams know which patients are to be discussed at each multidisciplinary team meeting so they can decide if there is anything they would like to offer input on, and also to give them the opportunity to bring any cases they would like to discuss to the meeting.

Developing closer joint working with mental health teams has been identified as one of the main priorities for service development by staff in the integrated care teams.

Wellbeing co-ordinators

Wellbeing co-ordinators in each integrated care team play a critical role in promoting positive mental health and wellbeing among the people supported by the team. Their main role is to help connect people with local voluntary and community sector services – particularly people at risk of social isolation and in need of some extra support, or who are known to be struggling emotionally. By tackling issues such as social isolation, the intention is both to prevent people developing mental health problems such as depression and to support the recovery of those with existing mental health problems.

The aspiration is to widen the wellbeing offer in the integrated care teams over time, with the addition of peer coaches, self-management courses and (potentially) other resources such as dementia care navigators.

Primary care mental health service

This is another service that predates the vanguard programme, originally consisting mainly of community psychiatric nurses, nurse therapists and psychologists embedded in primary care. It includes the local IAPT services but is also able to offer services to a much wider range of patients, including people with long-term conditions and/or persistent physical symptoms. It can also act as a discharge pathway out of secondary mental health services. As part of the MCP programme, additional funding has been made available for extra nursing staff and a half-time consultant liaison psychiatrist, and a link worker arrangement has been established with the integrated care teams as described above. The addition of a liaison psychiatrist has enhanced the team's ability to work at the interface of physical and mental health, with the intention of allowing more to be done in primary care.

Mental health in care homes

As part of the West Cheshire Way MCP vanguard, mental health input into care homes has been redesigned. A consultant older people's psychiatrist works alongside community psychiatric nurses, GPs, advanced nurse practitioners and community matrons to provide support into nursing homes, with plans to expand this model to all care homes over time. A pharmacist will also be added to the team in future to conduct medication reviews. The service is now much more proactive, and includes education of care home practitioners rather than a referral and treatment model. Care home staff are supported to provide better care, using a quality improvement methodology.

Outcomes

- Local leaders involved in the West Cheshire Way vanguard report that having rapid access to mental health nurses has meant there are now fewer referrals from integrated care teams to specialist mental health services, as well as better quality care (eg, through joint case working).
- Stronger relationships between mental and physical health professionals allow staff to ask for informal advice without making a referral to mental health services, with this being reported to lead to a more seamless experience for patients.
- Wellbeing co-ordinators have supported discharge from integrated care teams by putting appropriate voluntary and community sector resources in place.
- Quantitative assessment of the impact of integrated working is ongoing.

Key enablers

- The presence of wellbeing co-ordinators in integrated care teams is highly valued and was reported to have made a huge difference both to the people receiving the service and also to members of the team, who are now in a better position to enable people to recover in a more holistic way rather than being reliant on medical intervention.
- There is a history of strong primary care-based approaches to mental health in West Cheshire, which provided the MCP with good foundations to build on. In addition to the primary care mental health service already described, every GP practice in the area has a mental health lead, and these leads come together on a monthly basis to update their skills and discuss service improvements. A local enhanced services (LES) payment is used to support mental health skills development in primary care.
- Giving mental health professionals protected time to conduct educational work with integrated care teams was seen as an important way of equipping these teams with the knowledge and skills they need in relation to mental health.
- Some interviewees commented that it was very helpful for mental health services and community services for physical health to be provided by the same organisation. In particular, it means that there is a shared management structure, with service managers across the two sectors working to the same set of priorities and with a similar ethos.
- Co-location of staff was also identified as an important enabler, making it easier to build cohesive integrated care teams.

Further information

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The **Royal College of Psychiatrists** is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

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The new models of care being developed and tested in the vanguard sites aim to dissolve traditional boundaries in the health system, and are being seen as a 'blueprint for the future of the NHS'. But how far is mental health being integrated into these new approaches?

Mental health and new models of care: lessons from the vanguards looks at the opportunities to improve care by embedding mental health expertise within multispecialty community providers, primary and acute care systems and other care models. It describes some of the progress made so far in the vanguard sites, and draws on their experience to offer lessons and insights for local leaders in other parts of the country.

The report finds that:

- despite some positive steps in vanguard sites, the full opportunities to improve care through integrated approaches to mental health have not yet been realised
- many sites are finding that improved access to mental health support can be a highly valuable component of integrated care for people with complex and ongoing care needs
- in some areas, developing new models of care has created an opportunity to improve relationships and support learning between professionals working in physical health and mental health care
- success is more likely where patients, service users and carers are involved early in the design process and in implementation.

Other local areas rolling out new care models should aim to go further than the vanguards in integrating mental health into care pathways in four key areas: complex needs, long-term care, urgent care, and population health. Those leading sustainability and transformation plans (STPs) should draw on early lessons from the vanguards to put mental health care at the centre of their plans.

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Department of Health

NHS England

Achieving Better Access to Mental Health Services by 2020

Contents

Foreword by Rt. Hon. Norman Lamb – Minister of State for Care and Support

For decades the health and care system in England has been stacked against mental health services and stacked against the people who use them. The extraordinary gravitational pull of acute hospitals has distorted the distribution of resources, an imbalance that has been perpetuated and exacerbated by treatment targets and payment systems for physical health which have diverted resources from mental health services.

In 2012, the Government called a halt to this institutional bias, signalling its intent by putting it into law that appropriate physical and mental health services are commissioned. The sustained historic failure to properly value mental health services is now finally beginning to be reversed, as we increasingly appreciate the importance of good mental health and understand the terrible burden poor mental health places on individuals, families and society.

This is the right thing to do, both morally and ethically. Investment in effective treatment for mental health problems relieves the suffering of individuals and for many transforms their lives and the lives of their families and friends. Good and timely treatment reduces the risk of suicide and self-harm. Prevention and early intervention lead to fewer people being admitted to treatment in restrictive settings and against their wishes. Prevention and early intervention to support children and young people with mental illness can dramatically improve the quality of their lives and future. The moral case for change is strong.

But it is also the right thing to do economically. It is estimated that mental health problems cost the country as much as £100 billion each year – including the costs to individuals and society of treating preventable illness, the impact on quality of life, lost working days and lost income.[1] Investment in promotion, prevention and effective mental health care and treatment is not just good for individuals, and for families, but good for society as a whole.

The Government has already taken important steps to improve mental health services:

- ending the unfair exclusion of mental health services from the legal right to choose;
- a drive to improve mental health services for all ages – children, young people and older people, and not just working age adults;
- the CQC has introduced a new, robust and independent inspection regime for mental health, drawing on hard data, on-the-ground expert inspection and patient and staff views of services to determine whether they are safe, effective, caring, responsive and well-led;
- rapid expansion of the Improving Access to Psychological Therapies programme, with over 2.4 million people have entering treatment, and over 1.4 million completing it so far. Over 700,000 people having entered treatment during 2013-14. This compares to just 340,000 in 2010.[2]
- transformation of children and young people's services through the £54 million funding invested in service improvement and training;
- publication of the mental health Crisis Care Concordat, an agreement between over 20 national bodies that makes clear the care and support that people in crisis need, so that far fewer vulnerable people find themselves inappropriately in police cells; and

1 Centre for Mental Health 2010, The economic and social costs of mental health problems in 2009/10, London: Centre for Mental Health.

2 Health and Social Care Information Centre, September 2014, Psychological Therapies, Annual Report on the use of IAPT services – England, 2013-14.

- much faster assessment and support for people in the criminal justice system, through liaison and diversion services.

Our commitments in *Closing the Gap*[3] and *No Health Without Mental Health*[4] stand and our achievements in delivering the actions from these plans are an important start. But this is not the first time that governments have expressed a determination for change in this area, and today there is still far to travel. To make parity of esteem a reality by 2020, we need urgent reforms to the incentives in the system that drive investment and spending. We need standards for access to mental health treatment for people of all ages that balance the equivalent standards for physical health. We need the same quality of data and transparency about performance for mental health services for people of all ages so that long waits for effective treatment are visible and have to be tackled.

This document sets out a pathway from Government to deliver that parity, with £40 million additional spending to kick start change in the current year, and a further £80 million freed up for 2015/16. That will enable the setting of access and waiting time standards – the first of their kind in mental health services. This is important – we know that early treatment can make a big difference. For example, treating young people at risk of developing a psychosis early can transform their life chances, help them to get or stay in work and to lead productive and healthy lives. We also know that the absence of mental health access and waiting standards (where such standards exist in physical health) has resulted in mental health services losing out on funding.

The next Government will face important choices about how fast to drive further improvements in subsequent years, but the plans in this document are a practical blueprint for how genuine change could be achieved by 2020.

There is so much to do, but in saying that we should recognise also that we are at the forefront as a country in raising the standard for mental health and in making a stand for people who need timely access to world class mental health treatment and support and early intervention.

No other country in the world is planning for change on this scale. This vision marks a major departure in its intent to rebalance radically our health and care system. We owe it to those with mental health problems to succeed and to children, young people and their families to make sure that their problems are addressed early. People deserve treatment as soon as their problems emerge, rather than waiting until they are in crisis. They deserve the same standards of access to treatment as people with physical illness. They deserve the same focus on recovery. We have a duty to secure equal rights for people with mental health problems. Nothing less is acceptable.

Rt. Hon. Norman Lamb
Minister of State for Care and Support

3 Department of Health, January 2014, Closing the Gap: Priorities for essential change in mental health.

4 Department of Health, February 2011, No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.

Foreword by Simon Stevens – Chief Executive, NHS England

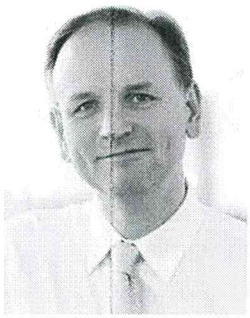
Mental health problems are the largest single cause of disability, representing a quarter of the national burden of ill-health, and are the leading cause of sickness absence in the UK.

This makes it all the more indefensible that there is such a large "treatment gap" with most people with mental health problems receiving no treatment and with severe funding restrictions compared with physical health services.

One consequence: people with mental illness die on average 15-20 years earlier than other people – one of the greatest health inequalities in England.

That is why, achieving "parity of esteem" between mental and physical health services is so important for the NHS, and for the nation.

This document therefore sets out some of the concrete next steps we are committed to helping lead over the next five years. NHS England looks forward to working with our partners to deliver this critical agenda.



Simon Stevens –
Chief Executive, NHS England

Executive Summary

In *No Health Without Mental Health* and *Closing the Gap,* the Government set out its commitment to achieving parity of esteem for mental health. Timely access to services and then for treatment is one of the most obvious gaps in parity – whilst there are waiting time standards for physical health services, for mental health services, these standards simply don't exist. This plan sets out the immediate actions we will take this year and next to end this disparity and achieve better access to mental health services and our vision for further progress by 2020.

We have committed an additional £40 million funding boost for mental health services in 2014-15. This comprises:

- an investment of £7 million to end the practice of young people being admitted to mental health beds far away from where they live, or from being inappropriately admitted to adult wards; and
- an investment of £33 million to support people in mental health crisis, and to boost early intervention services, that help some of the most vulnerable young people in the country to get well and stay well.

This is just the start. From next year we will be introducing access standards and waiting time standards – the first of their kind in mental health services. An £80 million investment will deliver:

- Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks.
- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.
- A £30 million targeted investment will help people in crisis to access effective support in more acute hospitals.

This is an important moment when we will bring parity of esteem for mental health services a step closer. Putting access and waiting standards in place across all mental health services, and delivering better integration of physical and mental health care by 2020, will bring us much closer towards that aim.

Introduction – The Case for Change

1. Each year about one in four of us in the United Kingdom will have mental health problems.[5] One in ten children need support or treatment for their mental health condition.[6] These can range from short spells of depression or anxiety through to severe and persistent conditions that are massively disruptive, frightening and life threatening for those who experience them.

2. These mental health problems can also have a terrible impact on people's physical health. People with schizophrenia are almost twice as likely to die from heart disease as the general population,[7] and four times more likely to die from respiratory diseases.[8] For young people, mental illness is strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour.

3. So the impact of these conditions on individuals of all ages, their friends and families can be very high. The impact on society and the economy is massive if individuals are unable to access effective, timely treatment:

- A recent study estimated that mental illness costs the United Kingdom economy as much as £100 billion per year.[9]
- Mental illness results in 70 million sick days per year, making it the leading cause of sickness absence in the United Kingdom.[10]
- 44% of Employment and Support Allowance benefit claimants report a mental health and/or behavioural problem as their primary diagnosis.[11]
- More than 75% of adults who access mental health services had a diagnosable condition before the age of 18.[12]
- Mental health problems in children and young people are common and account for a significant proportion of the burden of ill health in this age range.[13]

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5 McManus S, Meltzer H, Brugha T *et al.* 2009 Adult Psychiatric Morbidity in England, 2007: Results of a household survey. Leeds: NHS Information centre for health and social care.

6 Green H, McGinnity A, Meltzer H *et al.* 2005 Mental Health of Children and Young People in Great Britain, 2004. Basingstoke: Palgrave Macmillan.

7 Hemingway H and Marmot M (1999) Evidence based cardiology. Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. *British Medical Journal* 318: 1460–1467; Nicholson A, Kuper H and Hemingway H (2006) Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146 538 participants in 54 observational studies. *European Heart Journal* 27(23): 2763–2774.

8 NHS England, Strategic and Operational Planning Guidance 2014-2019, Reducing mortality for people with serious mental illness (SMI).

9 Centre for Mental Health 2010, The economic and social costs of mental health problems in 2009/10, London: Centre for Mental Health.

10 Sainsbury Centre for Mental Health (2007) Policy Paper 8: Mental Health at Work: developing the business case. London: Sainsbury Centre for Mental Health.

11 Department for Work and Pensions, 2013, Disability and Health Employment Strategy

12 Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU).

13 Department of Health 2013, Chapter 10 of the Annual Report of the Chief Medical Officer 2012 Our Children Deserve Better: Prevention Pays

4. Much of this illness can be effectively treated. For many mental health problems people can recover completely, for others the severity and impact of the condition, and the lifetime cost can be dramatically reduced. In general terms, the treatments for mental health problems can be as effective as those for physical illness.

"Treating mental health problems early and effectively is a win-win situation" – *Marianne West, Service User and Carer*

5. Despite the high costs to individuals, society and the economy of mental ill health and although mental health professionals have a range of NICE-approved effective interventions at their disposal, we know that for decades there has been a persistent failure to reach all the people who need care and to support them to access timely and evidence-based treatment. It is estimated that as few as a quarter of adults with depression or anxiety receive treatment. For children and young people with a mental health problem, only a quarter receive treatment.[14] With more people coming forward to seek treatment each year – the result, we think, of greater awareness and reducing stigma – the long history of underinvestment in mental health means that services are not currently able to offer everyone the timely and evidenced-based treatment that people should rightly expect to receive.

6. The tendency of health services to see physical and mental health as separate things, and the lack of integration between services, means that important physical health problems and risks are far too often neglected. Given the high rates of heart disease and lung disease in people with mental health problems, it is striking that while over the past decade smoking has become taboo in nearly all of the NHS, in mental health services smoking is still sometimes tolerated as a necessary evil. It is also clear that the mental health needs of many people with long term conditions go untreated. This disconnect between mental and physical health is a very significant missed opportunity to improve both physical and mental health for all.

"NHS providers of mental health care welcome the ongoing focus on creating an integrated system that values both mental and physical health" – *The Foundation Trust Network*

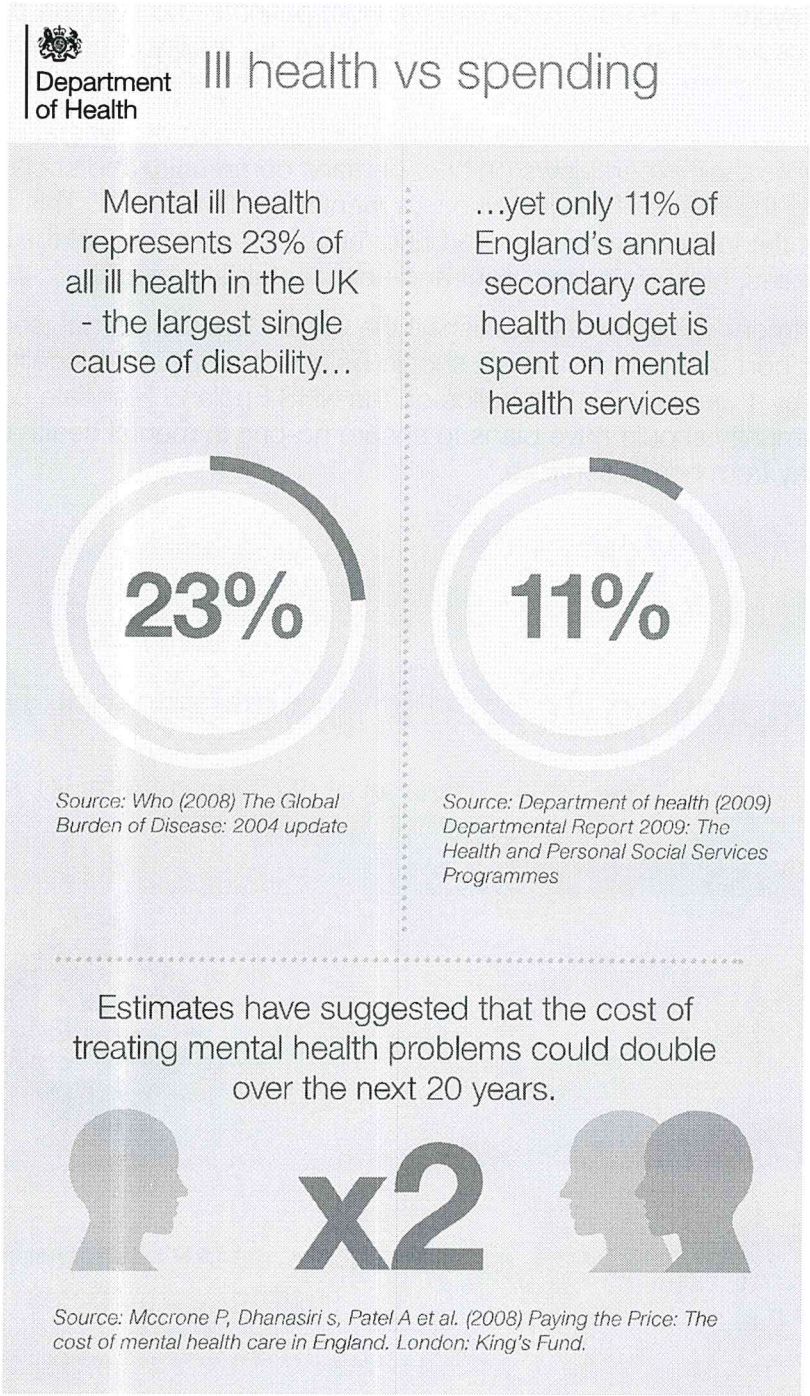
7. So there is a self-evident case (ethical, social and economic) for investing in mental health – its promotion, the prevention of mental illness and improving care, treatment and recovery. It is clearly of benefit to individuals, their friends and their families. But it is also good for the taxpayer, the citizen, the employer, schools and colleges and the NHS. The Government and the NHS has been taking significant strides forward in recent years to begin to realise this important policy opportunity to secure wide ranging social and economic benefits for the country.

8. In 2012 the Government set out its commitment that mental health services for all ages should enjoy parity of esteem with physical health services and since then a major programme of investment and standard setting will lay the ground work for significant improvements in the care that people with mental health problems receive.

9. Earlier this year the Department of Health, working closely with NHS England and the whole health system published *Closing the Gap: Priorities for Essential Change*, which set out 25 areas where urgent action was most needed. It highlighted the initiatives most likely to deliver early wins for people with mental health problems and identified the types of care and support, based on outcomes, that need to be delivered consistently across the country. This document is intended to complement the actions included in *Closing the Gap*. Since the launch of *Closing the Gap* good progress is being made on this agenda:

14 The Mental Health Policy Group – General Election 2015, A Manifesto for better mental health, August 2014.

- The Government has ended the unjust exclusion of mental health services from the right of choice in the NHS.
- Over 2.4 million people have entered evidence-based talking therapy for problems like anxiety and depression through the *Improving Access to Psychological Therapies* programme. Over 1.4 million people have now completed treatment[15] and, with continued focus from NHS England the programme is on track to meet its 2015 target of making talking therapies available to 15% of the estimated adult population who have depression and anxiety disorders.



15 Health and Social Care Information Centre, September 2014, Psychological Therapies, Annual Report on the use of IAPT services – England, 2013-14.

- The children and young people's Improving Access to Psychological Therapies programme is on track to transform services covering more than two thirds of young people in England. It is helping services to become more efficient, more evidence-based, and better focused on delivering improved outcomes for the children and young people that they work with. Children, young people and their families are being more closely involved in the design of treatment and tracking of its progress and impact.
- The Department of Health has ensured that the Care Quality Commission's new, independent and rigorous expert inspection regime for acute hospitals, following the Public Inquiry into Mid Staffordshire NHS Trust, is matched by an equally thorough inspection system for mental health trusts. Both patients and staff are being engaged by expert inspectors in making judgements about the quality of care in every mental health hospital in the country.
- The Chief Inspector of Social Care and the Chief Inspector of General Practice will be making public their expert views on how primary, community and social care services are meeting the needs of people who use mental health services. This substantial overhaul of the inspection system will bring much closer scrutiny of the quality of mental health services, highlighting excellent and unacceptable care alike.
- The Department of Health has published the Crisis Care Concordat (see box) setting out the support that people in crisis should be able to expect. All localities will be signed up by 1 January 2015. It builds on the NHS England Mandate commitment that every community should have plans to ensure no-one in mental health crisis should be turned away from health services.

- There has been real improvement to rapid assessment and support in the criminal justice system, through significant investment of £25 million in the development of more effective liaison and diversion services.
- The Police tell us that we are on the way to reducing by one third the number of people with mental health problems who end up in police cells after detention under section 136 of the Mental Health Act, and will press on to halve this number.
- We have also funded pilot schemes to trial 'street triage' – services in which mental health professionals support and advise police officers in their work protecting and helping people in mental health crisis. We will explore with NHS England how to ensure that street triage is commissioned wherever it is needed, and how to link most effectively with liaison and diversion services.

The Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, local government and the third sector came together and signed the Crisis Care Concordat. It focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

- Whilst there is still much to do to tackle stigma, there have been significant reductions in the number of people with mental health conditions reporting discrimination in some key areas of their lives, including employment, as a result of the Time To Change programme.
- A combination of healthcare and employment advice offers the best prospect of a sustained return to work for people with mental health problems. This is why the Department of Health, the Department of Work and Pensions and NHS England have started pilot schemes to test integrated models of mental health services and employment support. Employment is a key feature of the NHS Mandate and it is vital that health and employment services work together.
- We have published guidance on reducing the need for restrictive interventions.[16]

16 Department of Health, April 2014. Positive and Safe: reducing the need for restrictive interventions.

10. These are all significant improvements, but to move more quickly to parity of esteem, to demonstrate the urgency that people with mental health problems have a right to expect, we now need a step change, with a clear vision for parity of access in 2020 and a practical steps to make that vision a reality for people who depend on these services.

"This is an important first step to providing timely and responsive treatment for patients"
Prof Sir Simon Wessely, President Royal College of Psychiatrists

2020 – The Vision

11. Our aspiration is to put health care for people with mental health problems on an equal footing with care for people with physical health problems. This will deliver better outcomes and healthier lives. This plan sets out what could be achieved to improve the lives of people of all ages and from all groups.

12. People of all ages with mental health problems should receive at least the equivalent level of access to timely, evidence-based, clinically effective, recovery focused, safe and personalised care as people with a physical health condition. The physical needs of people with mental health conditions need to be assessed routinely alongside their psychological needs and vice versa.

13. What happens from 2015/16 to 2020 will be determined by the next Government in the context of a spending review. However, it is important to recognise that achieving parity of esteem for mental health services is not a short term ambition but one which will require sustained action over the next five years. Without committing or obligating that Government, we are setting out the areas we believe will be necessary to take action to progress on the country's journey towards parity of esteem for mental health services by 2020.

14. This would mean:

"This plan is an important first step towards achieving high quality support for people with mental health problems"
– Mind

(a) Outside of the NHS, whether at school, at work or at home, people feeling better supported to look after their own mental health.

(b) As with physical health, people with mental health problems being able to access evidence-based NHS assessment and treatment services that support recovery, in line with clear and clinically informed waiting time standards.

(c) Having a named accountable clinician to enable more coordinated, effective and personalised care.

(d) People with mental health problems receiving the right treatment at the right time and the right place in the least restrictive setting and as close to home as possible. This includes people who are referred through contact with the police or criminal justice system.

(e) People with mental health problems being better supported to live healthy lives, making real progress towards bringing life expectancy on a par with the rest of the population.

(f) At all levels, national, organisational and individual, the views of people being central to shaping the decisions that are taken.

(g) Children being able to access high quality care nearer to home, enabling them to keep in contact with family and friends.

(h) Services that are sensitive to the needs of local populations and the diversity within them seeking to eliminate discrimination and advance equality of access.

(i) Health and social care services, and other agencies, working together in a seamless way to achieve the best possible outcomes for people.

15. Achieving this requires a rebalancing of the incentives in the system which currently draw resources away from mental health services and towards services for the treatment of physical conditions. Effective payment models for mental health services should be developed that support and enable the commissioning of high quality, evidence-based, safe and recovery focused treatment. The mental health payment system should incentivise early intervention and the provision of integrated care in least restrictive settings close to home.

16. Better integration of physical and mental health care will deliver improved outcomes and better value across NHS funded services. Our Taskforce into child and adolescent mental health and wellbeing will deliver a stronger focus on joint working across agencies to ensure that all commissioners – whether in health, local government or education – share the same vision and will drive improvement. Integrated services should provide treatment and support from the earliest possible stage.

17. Access and waiting time standards for treatment in physical health will be complemented by access and waiting time standards for mental health. Starting in some key areas next year, for the next five years the vision is for all mental health services to guarantee people access to timely, evidence-based and effective treatment. In doing so the NHS will not only shorten the time that people go without treatment and support but also improve outcomes. This move, which in time would be set out in legislation and the NHS Constitution as is the case for physical health, could significantly level the playing field between mental health and physical health services.

18. The introduction of new standards, new payment and new commissioning regimes will drive a much richer set of data about the quality and performance of services for all ages and the outcomes achieved. Much more relevant data, open to patients, the public, providers and commissioners will help to drive improvement and expose and then eradicate unacceptably long waits for treatment. The maternity and children's dataset will produce a far clearer picture from next year of what is being provided and will put us in the best place to design new services that meet the needs of children and young people.

19. In the past 15 years, clear waiting time standards, tariffs and a strong commissioner focus have transformed waiting times for heart surgery, cancer treatment and a range of treatments for other physical illnesses. The measures set out in this document seek to bring balance and lay the foundations for a revolution in mental health care that could set a global example at the start of the next decade.

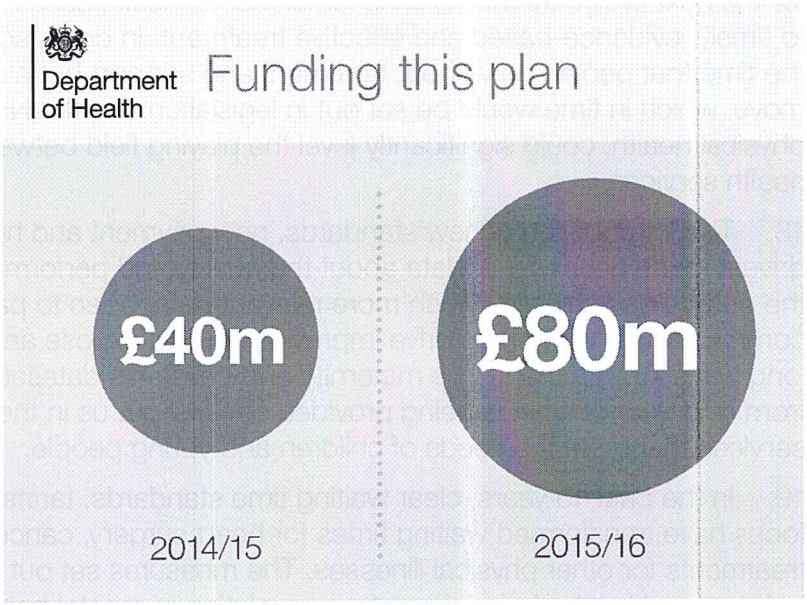
Delivering the Vision

20. This is an ambitious aim, and spending decisions are the prerogative of the next Government. The following sections of this document set out three phases which could, with sustained commitment, deliver genuinely transformational change in NHS mental health services by 2020. The focus here is on bringing the right incentives, standards and transparency to the healthcare system, whilst recognising that partners in public health, local government, education, the voluntary sector and wider will all need to play an important part in improving lives.

"This plan is a positive step for both patients and the NHS, and it is essential to commit to action and implementation of the plan to deliver high quality mental health services in the future"
Joy Chamberlain, Chair The Independent Mental Health Services Alliance

21. In the first phase, although money is currently very tight in the NHS, we have freed up a further **£40 million in 2014/15**, recognising that investment now will not only benefit the wider NHS, but lay the groundwork for further improvement in later years. This money will be used to build capacity to enable the NHS to meet tough access and waiting time standards next year and beyond and to develop the information and data systems needed to support this.

22. The second phase, next year, will see the ground-breaking introduction of access and waiting time standards in some key areas of mental health services, with investment in the strategy doubled to **£80 million to drive progress.** This will mean that from next year people with common mental health problems will get faster access to the most effective evidence-based treatment, that vulnerable young people will receive the treatment they need to boost their life chances, and that crisis services will be improved.



23. Subject to future resourcing decisions following the next Spending Review, the final phase from 2016 to 2020, would see the continuous staged roll out of these new access and waiting time standards across the whole of mental health services in England, each year bringing the reality of **parity of esteem** between services for mental illness and physical illness that bit closer.

Phase 1 – 2014/2015: Laying the Groundwork

24. In the current financial year we will continue to drive the implementation of *Closing the Gap,* ensuring the continued delivery of the Improving Access to Psychological Therapies programme and securing nationwide sign up to the Crisis Care Concordat. The Children and Young People's Improving Access to Psychological Therapies programme will continue to be rolled out across the country, so that more children and young people are able to access high quality services where and when they need them.

Source: Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy, Department of Health, 2011

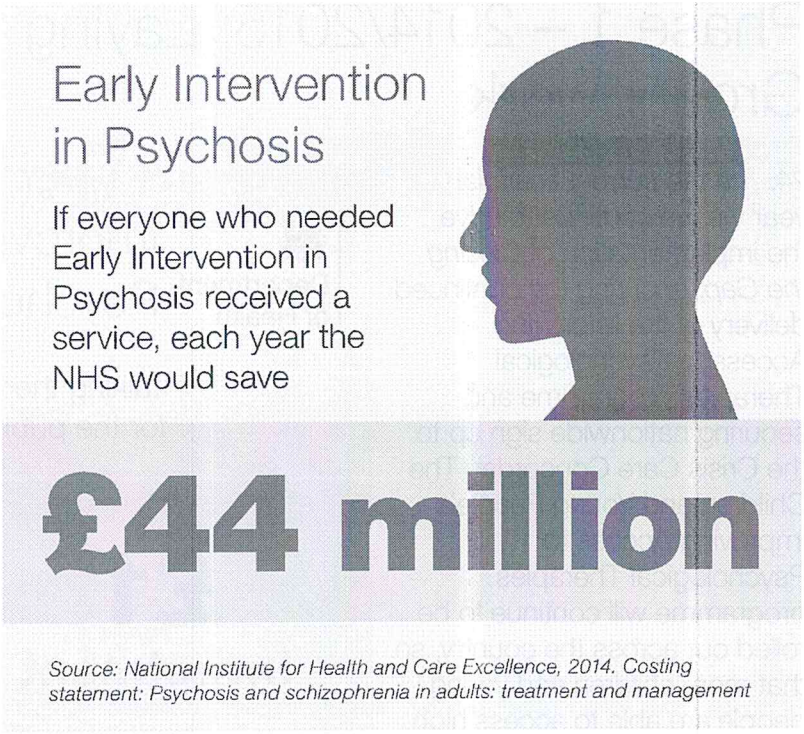
25. The Children and Young People's Mental Health and Well-Being Taskforce is bringing together experts on children and young people's mental health and those with knowledge of wider system transformation from across the education, social care and health sectors. The Taskforce will make recommendations to achieve better outcomes for children and young people with mental health problems. It will consider what changes and improvements are needed in the current operational systems, the system levers which can be applied, and identify innovative, cost-effective and affordable solutions for achieving progress.

26. At the same time, using **a new £40 million funding boost for mental health services,** secured to kick-start delivery of the 2020 vision, we will be building capacity in some priority areas in order to prepare for the introduction of new access standards in the following year.

27. First, following the recent review of specialist child and adolescent mental health inpatient services,[17] **NHS England are investing £7 million immediately in 50 new inpatient beds and in better case management, to ensure that children with specialist inpatient needs are cared for in appropriate settings.** This should bring an end to the unacceptable practice of young people being admitted to institutions far away from where they live, or from being inappropriately admitted to adult wards. The additional capacity should also help to minimise the number of young people who are admitted to restrictive care settings. At the same time, NHS England will work to consider the longer term capacity requirements to ensure that provision for this vulnerable and important group of people is put on a sustainable basis for the future. This work will include supporting faster implementation of good practice commissioning of child and adolescent services both in the community and inpatient settings.

17 NHS England, CAMHS Tier 4 Steering Group, July 2014. Child and Adolescent Mental Health Services Tier 4 Report.

28. The remaining **£33 million is being invested in early intervention services for psychosis and in crisis care.** In 2011, *No Health Without Mental Health* highlighted the effectiveness of early intervention service for people with psychosis. There is good evidence that these services help young people to recover from a first episode of psychosis and to gain a good quality of life. NICE found these services reduce the likelihood that individuals with psychosis will relapse or be detained under the Mental Health Act, potentially saving the NHS £44 million each year through reduced hospital admissions.[18] In addition to the benefits to people with psychosis highlighted by NICE, these services have wider benefits:



Source: National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management

- 35% of people under their care are in employment, compared with 12% in traditional care;
- they reduce the likelihood of an individual receiving compulsory treatment from 44% to 23% during the first two months of psychosis; and
- they reduce a young person's suicide risk from 15% to 1%.[19]

29. So there are very real gains to be made quickly through investment in this area. At the same time as providing pump-prime funding to Clinical Commissioning Groups to develop these services, NHS England will be investing further in developing commissioning support tools and appropriate levers and incentives, including payment models.

30. The additional resources will be shared with substantial new investment in **crisis services.** The most common causes of mental health crises vary but largely comprise severe depression, psychosis relapse, dementia, self-harm and alcohol related episodes. The investment here is designed to accelerate the full implementation of local crisis care concordat-compliant services and could focus on two key areas where we know we can have the biggest impact: liaison psychiatry for all ages in accident and emergency departments; and crisis resolution home treatment teams.

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18 National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management.

19 Rethink Mental Illness, March 2014. Lost Generation: why young people with psychosis are being left behind, and what needs to change.

31. **Psychiatric liaison services** provide mental health care to people of all ages who are being treated for physical health conditions in general hospitals. There is strong evidence that some models of liaison psychiatry eg the RAID (rapid, assessment, interface and discharge) model can deliver clinically and cost-effective care to patients in general hospitals with a range of mental health problems. Some models have been shown to reduce the rate of hospital admissions and admissions to care homes for people with dementia, reduce repeat presentations to accident and emergency for people who have self-harmed and reduce admissions for people presenting with depression and a physical health problem. One study suggested that the RAID model can save an average of £5 million a year for a hospital by reducing both admissions and length of stay. In 2014/15 we are providing funding for liaison psychiatry which will move us closer to a more comprehensive service that for every £1 of investment, should realise a £2.50 to £3 saving in the acute sector.[20] **Crisis Resolution Home Treatment Teams** will be supported. These services are an important service which can help reduce admissions to acute inpatient beds; facilitate early discharge from acute beds; and offer an alternative to admission through the delivery of intensive care and support to people at home.

Source: Department of Health, October 2014. Impact Assessment: Access and waiting time standards for 2015/16 in mental health services

32. Finally, at the same time as investing in these services, we will also begin to invest in the infrastructure needed to rebalance the system for parity between physical and mental health services, laying the ground work for an equivalent system of access and waiting time standards, levers and incentives, commissioning and payment models that will place mental health services for all ages on a more level playing field with physical health. For the current year, the infrastructure priorities for the system will be:

(a) **Establishing the baseline position**: carrying out analysis on the level and reliability of information that currently exists for mental health services across care pathways, which would help to support the work to develop access and waiting time standards.

(b) **Strengthening national datasets**: develop definitions and data specifications that are fit for purpose to enable robust and consistent analysis of patient pathways and measurement of actual waiting times.

(c) **Improving data collection, reporting and assurance:** assess whether there is appropriate IT infrastructure in organisations to support data capture: improve the quality of clinical coding and datasets; and establish national protocols for reporting and assurance.

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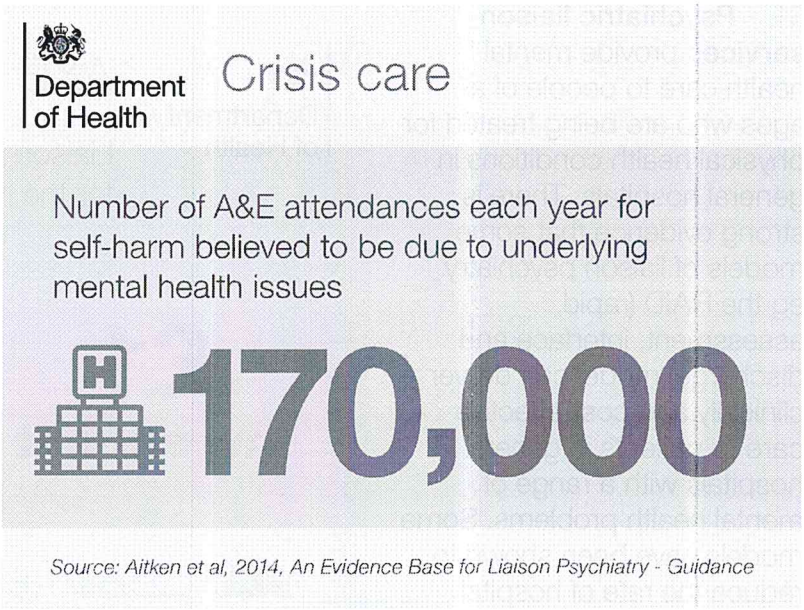
20 Department of Health, October 2014. Impact Assessment: Access and waiting time standards for 2015/16 in mental health services.

(d) **Establishing best practice waiting time benchmarks** for different services, taking account of local circumstances.

(e) **Collecting data on out of area placements.**



Phase 2 – 2015/2016: Implementing the first standards

33. **In 2015/16 a further £80m will be freed from existing budgets**, enabling introduction of the first access and waiting times standards of their kind – lines in the sand – to be set on parity of esteem for mental health services.

34. The refreshed NHS mandate for 2015/16 will contain the commitment that NHS England will begin planning for countrywide service transformation of children and young people's Improving Access to Psychological Therapies. As set out in *Closing the Gap* 100% roll out should be achieved by 2018.

35. In three key areas where we have invested this year, we have agreed that the NHS Mandate for 2015/16 will introduce three access standards as a crucial starting point on a journey to parity of esteem when, with the right will, our ambitions of parity can be fully realised.

Action to deliver better access to mental health services in 2015/16

In 2015/16 we will introduce the following access and waiting standards:

- 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral.
- More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.
- £30m targeted investment on effective models of liaison psychiatry in more acute hospitals. Availability of liaison psychiatry will inform CQC inspection and therefore contribute to ratings.

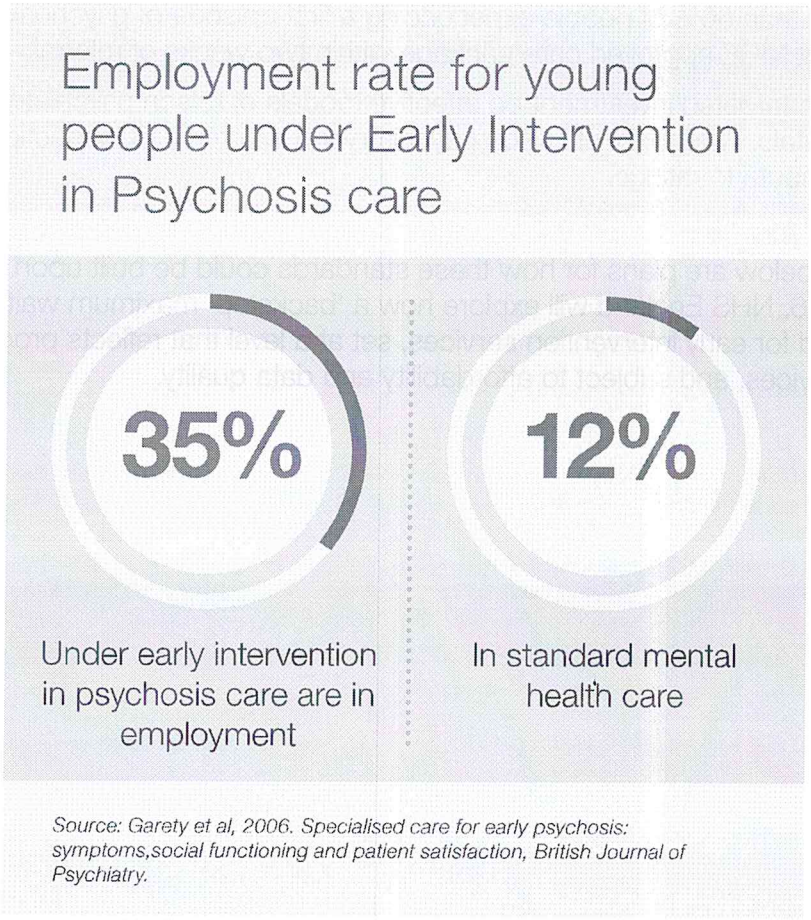
36. Set out below are plans for how these standards could be built upon in future years. During 2015/16, NHS England will explore how a 'backstop' maximum waiting standard could be established for early intervention services, set at a level that reflects progress on improving access to services, and subject to affordability and data quality.

Phase 3: Delivering Parity

37. The third phase will, subject to views of the next Government and in the context of the next spending review, look to build on progress this year and next with a view to go further and faster.

"Introducing a two week maximum waiting time for Early Intervention in Psychosis (EIP) services will change lives" – *Rethink Mental Illness*

38. The three standards set out above should be seen as just a starting point in an ambitious programme that by 2020 would aim to provide a comprehensive set of access and waiting time standards, payment models, data streams and commissioning processes that brings the same rigour to mental health services as is seen in physical health services. For example, we would like to see 95% of people referred to the Improved Access to Psychological Therapies programme being treated within six weeks of referral, 95% of people experiencing a first episode of psychosis being treated with a NICE approved care package within two weeks of referral, all acute trusts having a liaison psychiatry service for all ages appropriate to the size, acuity and specialty of the hospital and rapid access to services within 24 hours for post-partum psychosis, in the perinatal period for women who have a mental health condition.



Source: Garety et al, 2006. Specialised care for early psychosis: symptoms,social functioning and patient satisfaction, British Journal of Psychiatry.

39. Starting this year, the Department of Health and NHS England will work together with mental health system partners to develop detailed proposals for the introduction of further access and waiting time standards from 2016 onwards. This work will also consider relevant commissioning and payment models and reporting infrastructure to underpin delivery.

40. An early priority will be the development of standards for access and waiting times for the treatment of eating disorders, based on piloting of different models of care, to examine the case for a better mix of community and inpatient care. NHS England will analyse the data on provision of existing services, and access to and waiting times for these services across a whole region, with a view to piloting standards during 2015/16 and introducing standards in future years.

41. Furthermore, we will consider developing an access and/or waiting standard for rapid access to mental health services for women in pregnancy or in the post natal period with a known or suspected mental health problem.

"Timely and effective care can avert later costs and transform people's lives"
– Centre for Mental Health

42. In addition to work on these key access and system tools, the mental health system will set out further proposals in order to ensure progress on a broader range of fronts. For example:

- NHS England will be exploring commissioning approaches with CCGs which better **integrate the prevention of physical ill-health into mental health services for all ages.**
- NHS England and Public Health England will signal how smoke free policies can be implemented, and how **access to smoking cessation services** can be delivered in secure mental health services.
- Our expectation is that all in-patients will have a thorough **assessment of their physical health needs** on admission, including obesity, which is a significant health risk for people receiving care as inpatients. This needs over time to extend beyond inpatient care to community patients and primary care.
- Having a **named accountable clinician** would enable more coordinated, effective and personalised care. NHS England and DH will work with experts, including people who use services, to set out how this could be achieved.
- NHS England will extend **Personal Health Budgets** to people who use mental health services, giving people more power to shape their own care.

43. Furthermore, a clear strategy for improving the commissioning of specialised mental health care will be developed, including secure mental health services, perinatal mental health services, services for people with personality disorder, and mental health services for the deaf. The aim should be to make improvements each year.

44. The recommendations of the Children and Young People's Taskforce will also become available later in 2014/15 and will help inform our efforts to improve specialist mental health care for children and young people, with appropriate actions put in place as quickly as possible. They will enable more joined-up commissioning approaches across whole care pathways to deliver improved mental health outcomes for children and young people.

Conclusion

45. The pace of delivery will be a matter for the next Government, but in this year and next there is now a clear plan, once and for all time, to start the process bringing an end to the historic imbalance in investment between physical and mental health services and secure genuine parity of esteem between the two. There is a moral imperative that underpins that decision and a powerful social and economic rationale as well.

46. One of the central approaches of talking therapy is to restore balance in people's lives by helping them to challenge false beliefs and assumptions that underpin their judgements and decisions about their lives. Equally in the health and care system everyone needs to be conscious of holding false beliefs and assumptions about historic patterns of behaviour on mental health services. In looking to ensure the realisation of the vision for 2020, future decision makers need to be clear that spending on mental health is an investment, not a debit, and one which, if invested carefully, can transform the lives of individuals, communities and society. The challenge is there to be taken up.

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Prevalence of Mental Disorders among Prisoners in the State of Sao Paulo, Brazil

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Abstract

Objective: To determine the prevalence of psychiatric disorders in the prison population in the State of São Paulo, Brazil.

Methods: Through stratified random sampling, 1.192 men and 617 women prisoners were evaluated for the presence of psychiatric disorders by the Composite International Diagnostic Interview, 2.1 version, according to definitions and criteria of International Classification of Diseases (ICD-10). The prevalence estimates of mental disorders and their respective 95% confidence intervals were calculated and adjusted for sample design through complex sample analysis.

Results: Lifetime and 12-month prevalence rates differed between genders. Lifetime and 12-month prevalence of any mental disorder was, respectively, 68.9% and 39.2% among women, and 56.1% and 22.1% among men. Lifetime and 12-month prevalence of anxious-phobic disorders was, respectively, 50% and 27.7% among women and 35.3% and 13.6% among men, of affective disorders was 40% and 21% among women and 20.8% and 9.9% among men, and of drug-related disorders was 25.2% and 1.6% among women and 26.5% and 1.3% among men. For severe mental disorders (psychotic, bipolar disorders, and severe depression), the lifetime and 12-month prevalence rates were, respectively, 25.8% and 14.7% among women, and 12.3% and 6.3% among men.

Conclusions: This is the first large-scale epidemiological study performed with the prison population in Brazil, revealed high rates of psychiatric disorders among men and women. Many similarities, as well as some differences, were found between our results and those of studies conducted in other countries. The differences observed are more likely due to the peculiarities of the prison systems in each country than to the diagnostic criteria adopted in the studies. This fact reinforces the importance of conducting such studies as part of planning and development of appropriate policies for the particular mental health needs of specific prison populations.

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Introduction

Epidemiological studies conducted with prisoners in several countries have shown a high prevalence of psychiatric morbidity. The prevalence of severe mental disorders can be 5 to 10 times higher than in the general population [1]. In European prisons, the prevalence of psychotic disorders is around 5%, of depressive or anxiety disorders is around 25%, and of substance-related disorders is approximately 40% [2]. An extensive literature review done in 24 countries revealed rates of depression of around 10% and 14% in male and female prisoners, and approximately 4% of psychotic disorders in both genders [3].

Brazil has approximately half a million prisoners and the State of São Paulo has one of the largest prison populations in the country, approximately 40% of the national total. Nevertheless, information about prisoners' health conditions is scarce. A few studies have reported high rates of health problems in Brazil's prison system, including mental disorders. In a women's prison in São Paulo, the prevalence of common mental disorders was reported as being 26.6% [4]. A study conducted in Salvador, in the northeast of Brazil, with 497 prisoners in closed and semi-opened systems reported high prevalence rates of mental disorders. The rates found for prisoners in closed systems were 5.2% for bipolar affective disorder, 17.6% for depression, and 1.4% for psychotic disorders. For prisoners in semi-open systems, the rates were 10.1% for bipolar affective disorder, 18.8% for depression, and 12.6% for psychotic disorders [5].

Knowing the mental health needs of prisoners is crucial in order for prison systems to develop appropriate health care programs for this population. Thus, establishing the prevalence rates of mental disorders is of great importance [6]. This study aimed to determine the prevalence of mental disorders in the prison population in the state of São Paulo, Brazil.

Methods

Ethics Statement

This study was approved by the ethical committee of the Federal University of Sao Paulo (CEP 1051/05) and the State of Sao Paulo Department of Penitentiary Administration (process n. CS 295/05). All participants signed an informed consent to participate in this study. Individuals that declined to participate were not disadvantaged in any other way by not participating in the study.

We conducted a cross-sectional study with a probabilistic sample of 105 prisons with closed regime (5 female prisons – FP, 4 female resocialization centers – FRC, 32 temporary detention centers for men – TDC, and 64 male prisons – MP).

Prisoners in custody who consented to participate in the study were included whereas those in maximum-security units, or in custodial hospitals, were excluded for reasons of operational difficulty. Ethnicity classification was determined by subject. It was delivered to the respondent a card containing the different ethnic groups in Brazil (used by IBGE - Brazilian Institute for Geography and Statistics). The survey was conducted from May 2006 to January 2007.

The sample was selected using multistage sampling with probability proportional to size. Five administrative regions of the State of São Paulo responsible for prison administration were considered as strata. Male inmates were randomly selected from four units drawn in each stratum (20 randomly selected units, 10 MP and 10 TDC). Female inmates were randomly selected from the nine prison units of the State of São Paulo (five prisons and four rehabilitation centers).

The following parameters were considered for calculation of the sample size: a) population size in each stratum, b) estimated prevalence of 2% and minimum acceptable frequency of 1%, c) confidence level of 95%, and d) estimated loss of 10%. Based on these parameters, a total of 2,320 interviews was foreseen. The final sample was formed of 1.192 men and 617 women (response rate 77.9%), with a loss of 26.8% for men and 10.5% for women. The main causes of sample losses were: difficult access to prisoners (n = 336), refusals (n = 135), prison transfer (n = 16), and errors in the identification data (n = 24). The interviewers or study coordinator had no direct access to the raffled interviewed, the invitation to participate in the study was conducted by a prison guard, and if the subject refuses to participate no other information was given about him/her to the team study.

Instruments

The validated Brazilian version of the instrument "Composite International Diagnostic Interview" (CIDI), version 2.1, was used for diagnosis of psychiatric disorders [7] [8] [11]. CIDI is a standard structured questionnaire, designed to be used by trained non-clinician interviewers. It generates psychiatric diagnoses according to criteria of the International Classification of Diseases, 10th edition (ICD-10) and the Diagnostic and Statistic Manual of Mental Disorders, 4th edition (DSM-IV). Because ICD-10 is considered an efficient procedure for best-estimate diagnosis [9], in this study the lifetime and 12 month prevalence rates of mental disorders were generated by ICD-10. To estimate the prevalence of severe mental disorders, the following disorders were grouped: schizophrenic, delusional, acute psychotic, schizoaffective, severe depression and bipolar affective. The CIDI was applied by law interviewers trained and supervised by trainers from CIDI Brazil Official Center. The Portuguese version of the CIDI 2.1 has been previously validated and adapted to Brazil's social and cultural context [7,10,11].

Statistical Analysis

The prevalence estimates of mental disorders and their respective 95% confidence intervals were calculated and adjusted for sample design through complex sample analysis [12]. The analysis was different for each gender. For men, the administrative regions of the state and the type of prison (MP or TDC) were considered as strata. Since the number of woman recruited was to small by type of prison facility we decided to collapse the two groups in the analyses. Prison units drawn in the first stage and the inmates, who were randomly selected in the second stage, were considered as clusters. In the first stage, two units were drawn in each stratum and in the second stage, the number of prisoners drawn was proportional to the size of the stratum and without replacement. For women, the administrative regions and the prisons were considered as strata. The inmates were randomly selected in proportion to the size of the stratum and without replacement.

Results

The characteristics of the prison population of the state of São Paulo are shown in Table 1. We can observe the predominance of white prisoners born in the state, with more than 5 years' education, and who were employed before being arrested. Gender differences were observed: most women were single, had more children and were paid less than men. Differences regarding the prison regime were also observed. Most of the individuals in prisons were aged 28–47 years and were not working while incarcerated. Those in TDC were younger.

Violent crimes (robbery, rape, murder, and bodily injury) were the main causes of imprisonment. This was more pronounced among men, because a high proportion of drug crimes (drug use and trafficking) was also found among women. Criminal recurrence was less frequent among women compared with men. We found that 76.4% of women and 52.3% of men were incarcerated for less than three years. In temporary detention centers, most of the prisoners (70.0%) were incarcerated for less than one year, and 12.3% remained at these units for more than two years.

Lifetime and 12-month prevalence of mental disorders differed between genders (Tables 2 and 3): rates of 56.1% and 21.5% were found among men, and 68.9% and 38.4% among women, respectively.

Considering the lifetime prevalence (Table 2), the anxious-phobic disorders were the most frequent, regardless of gender (50% women, 35.3% men) or prison regime. These were followed by affective disorders (40.8% women, 20.8% men), substance-related disorders (25.2% women, 26.5% men), and alcohol-related disorders (15.6% women, 18.5% men). Among the anxious-phobic disorders, the vast majority of prisoners had post-traumatic stress disorder (PTSD), followed by generalized anxiety and phobic disorders. Likewise, among the affective disorders, most prisoners had depressive disorder, followed by dysthymia and bipolar affective disorder.

The 12-month prevalence of mental disorders followed the same trend (Table 2). For both genders, the phobic-anxious disorders were the most prevalent (27.7% women, 13.6% men), followed by affective disorders (21%, 9.9%). Twelve-month prevalence of substance-related disorders was significantly lower than the lifetime prevalence. The most prevalent disorders among women were depression (18.8%), PTSD (16.1%), and generalized anxiety disorder (7.3%). Among men, the most prevalent were PTSD (9%), depression (6.9%) and generalized anxiety disorder (2.6%).

Table 1. Sociodemographic and criminal characteristics of the prison population in the state of São Paulo, Brazil (n = 1809).

Characteristics	Female population	Male population	
		Prisons	TDC[1]
	N (%)	N (%)	N (%)
Worked before being arrested			
No	240 (37.8)	166 (23.1)	94 (18.1)
Yes	377 (62.2)	510 (76.9)	422 (81.9)
Marital status			
Married	257 (39.9)	383 (56.2)	321 (64.9)
Single	356 (60.1)	292 (43.8)	188 (35.1)
Number of children			
0	100 (12.7)	207 (30.5)	204 (38.6)
1–2	274 (48.1)	293 (42.7)	221 (43.4)
3–4	174 (27.9)	122 (18.5)	73 (14.9)
5 or more	69 (11.3)	54 (8.4)	18 (3.1)
Remuneration			
No remuneration	252 (40.3)	175 (24.8)	101 (19.4)
Up to half minimum wage	165 (29.4)	129(19.2)	102 (19.3)
Between ½ to 1 minimum wage	104 (17.7)	203 (30.8)	191 (36.0)
More than the minimum wage	84 (12.6)	164 (25.2)	118 (25.3)
Work in prison			
No	310 (49.0)	348 (51.3)	458 (87.9)
Yes	323 (51.0)	331 (48.7)	63 (12.1)
Age (years)			
18–27	234 (35.6)	267 (38.1)	314 (59.9)
28–37	222 (37.3)	246 (36.2)	135 (27.1)
38–47	111 (20.2)	111 (17.1)	48 (9.2)
48–57	39 (5.0)	41 (6.8)	15 (3.0)
>57	11 (2.0)	11 (1.9)	4 (0.8)
Cause of prison			
Crimes against property	54 (7.2)	40 (5.6)	44 (9.8)
Drugs	161 (32.7)	61 (8.4)	56 (9.3)
Violent crimes	402 (60.1)	575 (86.0)	415 (80.9)
Recidivist			
No	464 (76.7)	395 (60.8)	297 (55.9)
Yes	147 (23.3)	277 (39.2)	215 (44.1)
Time of sentence fulfilled			
1 year	24.8 (121)	19.2 (127)	70 (356)
2 years	28 (181)	20.2 (135)	17.7 (83)
3 years	23.6 (132)	13.2 (92)	5.2 (25)
4 years or more	23.5 (178)	47.4 (310)	7.1 (34)

[1]Temporary detention center.

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High prevalence rates for severe mental disorders were found among prisoners. Women were more affected (25.8% lifetime prevalence, 14.7% 12-month prevalence) than men (12.3% lifetime prevalence, 6.3% 12-month prevalence). These rates also varied according to the prison regime. Populations in temporary centers presented a higher 12-month prevalence (8.7%) than those in prison (5.1%). Similarly, 12-month prevalence rates for depression were 10.0% and 5.3% among individuals in temporary centers and in prison, respectively, and 4.8% and 0.5% for alcohol-related disorders (Table 2).

Among men, lifetime and 12-month rates of psychiatric comorbidity were 34% and 58.5%, respectively. Among women, 12-month prevalence was 46.7% and lifetime prevalence was 69.9%. For both genders, affective disorders were more associated with other disorders. Among men, the association with 12-month and lifetime phobic-anxious disorders was 85.3% and 53.7%, respectively, 87.5% and 11.1% with 12-month and lifetime

Table 2. Lifetime prevalence of mental disorders in prison population of the state of São Paulo, Brazil (n = 1809).

Mental Disorders	Female population		Male population					
			Prison		TDC[1]		Total	
	%	95%CI[2]	%	95%CI[2]	%	95%CI[2]	%	95%CI[2]
	%	IC 95%	%	IC 95%	%	IC 95%	%	IC 95%
Schizophrenia	1.9	0.9–4.0	3.2	2.1–4.7	3.9	2.4–6.4	3.4	2.5–4.7
Other psychoses[3]	2.4	1.8–3.1	1.8	0.9–3.7	2.5	1.2–5.0	2.1	1.2–3.5
Affective disorders[4]	40.8	37.3–44.3	18.4	16.0–21.2	25.3	21.3–29.9	20.8	8.4–23.4
Mania	0.9	0.9–3.9	0.7	0.2–1.7	1.4	0.7–2.9	0.9	05–1.7
Hypomania	–	–	0.5	0.2–1.4	1.0	0.5–2.0	0.7	0.4–1.2
Depression	36.5	33.5–39.6	12.3	9.7–15.5	17. 8	14.9–21.2	14.2	12–16.8
Bipolar affective disorders	1.7	0.2–10.8	2.9	2.0–4.2	2.9	1.7–5.0	2.9	2.1–4.0
Dysthymia	6.4	4.4–9.2	4.8	2.7–8.5	5.0	3.6–6.9	4.9	3.3–7.2
Anxious-phobic disorders[5]	50.0	45.6–54.4	32.5	29.4–35.8	40.5	35.2–46.1	35.3	32.3–38.4
Phobic disorders[6]	15.6	13.8–17.6	6.4	4.7–8.6	12.4	4.9–27.7	8.5	5.0–13.9
Panic disorder	1.1	0.9–1.3	0.5	0.1–1.8	0.8	0.2–2.5	0.6	0.2–1.4
GAD	10.4	9.3–11.7	4.9	2.4–9.8	5.4	2.2–12.4	5.0	2.9–8.6
OCD	1.2	0.8–1.8	1.1	0.4–3.3	1.5	0.5–4.8	1.2	0.6–2.8
PTSD	40.2	35.3–45.2	26.4	22.8–30.3	33.4	26.7–40.8	28.8	25.2–32.7
Tobacco	38.4	33.3–43.7	32.5	28.1–37.3	33.4	30.2–36.7	32.8	29.7–36.1
Alcohol	15.6	13.4–18.0	18.0	14.6–21.8	19.6	13.8–27.1	18.5	15.4–22.1
Drugs	25.2	19.2–32.2	27.1	21.6–33.3	25.3	20.7–30.4	26.5	22.5–30.8
Severe mental disorder[7]	25.8	24.0–27.7	11.0	8.3–14.3	15.0	12.4–18.0	12.3	10.3–14.8
Any mental disorder (except tobacco)	68.9	63.5–73.9	54.1	49.2–59.0	60.0	55.4–64.5	56.1	52.5–59,8

[1]Temporary detention center;
[2]Confidence Interval;
[3]Delusional Disorder, Acute Psychotic, and Schizoaffective Disorder;
[4]Depression, Bipolar Disorder, Dysthymia, Hypomania, and Mania;
[5]Panic, Agoraphobia, Social Phobia, Obsessive Compulsive Disorder (OCD), Generalized Anxiety Disorder (GAD), and Pos Traumatic Stress Disorder (PTSD);
[6]Agoraphobia and Social Phobia;
[7]Schizophrenia, Delusional Disorder, Acute Psychotic Disorder, Schizoaffective Disorder, Severe Depression, and Bipolar Affective Disorder.
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psychotic disorders, 18.7% and 40.7% with alcohol-related disorders, and 2.7% and 52.3% with drug-related disorders. Among women, the association of affective disorders with 12-month and lifetime anxious-phobic disorders was 78.8% and 73.4%, respectively, 81.3% and 76.5% with 12-month and lifetime psychotic disorders, 60% and 68.3% with drug-related disorders, and 60% and 68.3% with alcohol-related disorders.

Differently from the prevalence identified in the study, the prevalence rate of self-reported mental disorders was 4.0% (95% CI: 3.3%–4.9%) among men and 3.3% (95% CI: 2.6%–4.1%) among women.

Discussion

High prevalence rates of mental disorders among prisoners in the state of São Paulo, Brazil, were found in this study. The lifetime and 12-month prevalence for any mental disorder was, respectively, 68.9% and 38.4% among women and 56.1% and 21.5% among men. These rates are two times higher than those found in the general population of São Paulo [13] [14] [15].

This is the first large-scale epidemiological study performed with the prison population in Brazil. For diagnosis of mental disorders, we used standardized and validated instruments covering a large part of the spectrum of diseases.

Some limitations can be identified in this study, such as the exclusion of personality disorders, specific phobia, and mental retardation. Furthermore, since the interviews were performed in prisons, information such as that related to the consumption of psychoactive substances, which may result in disciplinary action, may have been omitted. Part of the sample loss in this study was due to a rebellion that occurred in the prison system of São Paulo five months before the interviews were started. This fact led to enormous tension between staff and prisoners, hindering access to some of the individuals initially screened. Nevertheless, the overall prevalence rates of mental disorders found in the current study are similar to those reported in studies involving prisoners from other countries. The exclusion of prisoners from maximum security units and hospital custody may have influenced the prevalence of mental disorders in prison. However, in a study conducted in 2008 at a Custody Hospital in Rio Janeiro [16], the authors found a similar description of subjects as ours: men, single, low-income, low education, with a high prevalence of alcohol use disorder and other drugs. The authors also found a relationship with psychotic disorders, mental retardation, and personality disorders, as expected.

A systematic literature review showed that the prevalence of mental disorders among prisoners varies from 55% to 80% [17]. The lifetime prevalence among women prisoners from Canada

Table 3. Twelve-month prevalence of mental disorders in prison population in the state of São Paulo, Brazil (n = 1809).

Mental Disorders	Female population		Male population					
			Prison		TDC[1]		Total	
	%	95%CI[2]	%	95%CI[2]	%	95%CI[2]	%	95%CI[2]
Schizofrenia	1.5	0.9–2.4	1.8	1.1–2.9	2.1	1.2–3.8	1.9	1.3–2.8
Other psychoses[3]	0.5	0.1–3.0	0.7	0.2–2.4	2.0	1.1–3.7	1.1	0.6–2.1
Affective disorders[4]	21.0	16.8–25. 9	7.7	6.1–9.6	14.1	11.2–17.6	9.9	8.3–11.7
Mania	0.6	0.1–3.4	0.2	0.1–0.4	0.4	0.1–1.7	0.3	0.1–0.6
Hypomania	–	–	–	–	0.4	0.1–1.5	0.1	0.0–0.5
Depression	18.8	17.3–20.4	5.3	4.0–6.8	10.0	8.1–12.2	6.9	5.8–8.1
Bipolar affective disorders	1.4	0.2–8.7	1.5	0.9–2.5	2.0	0.6–6.2	1.7	0.9–3.0
Dysthymia	5.2	4.4–6.1	2.1	0.9–4.7	1.4	0.7–2.8	1.9	1.0–3.5
Anxious-phobic disorders[5]	27.7	25.6–29.9	12.2	10.3–14.4	16.4	13.2–20.2	13.6	11.9–15.5
Phobic disorders[6]	7.3	6.6–8.0	2.4	1.2–4.6	3.3	1.5–7.4	2.7	1.6–4.6
Panic disorder	0.1	0.0–1.1	0.2	0.0–1.5	0	–	0.1	0.0–1.0
GAD	7.3	6.2–8.7	2.4	1.5–3.7	3.1	1.2–8.2	2.6	1.6–4.2
OCD	1.0	0.8–1.2	0.3	0.1–1.3	0.6	0.1–2.4	0.4	0.1–1.1
PTSD	16.1	14.9–17.4	7.8	6.3–9.8	11.1	8.3–14.6	9.0	7.5–10.7
Tobacco	25.4	21.1–30.1	13.4	11.3–15.7	17.4	14.4–20.9	14.8	13.0–16.7
Alcohol	2.4	1.4–2.7	0.5	0.1–1.6	4.8	2.3–9.6	1.9	0.9–4.1
Drugs	1.6	0.9–2.7	1.6	0.6–4.4	0.8	0.3–2.0	1.3	0.6–3.0
Severe mental disorder[7]	14.7	12.0–17.9	5.1	3.8–6.8	8.7	6.9–10.9	6.3	5.1–7.7
Any mental disorder (except tobacco)	38.4	34.3–42.7	19.1	16.6–21.8	26.2	22.1–30.9	21.5	19.4–23.9

[1]Temporary detention center;
[2]Confidence Interval;
[3]Delusional Disorder, Acute Psychotic, and Schizoaffective Disorder;
[4]Depression, Bipolar Disorder, Dysthymia, Hypomania, and Mania;
[5]Panic, Agoraphobia, Social Phobia, Obsessive Compulsive Disorder (OCD), Generalized Anxiety Disorder (GAD), and Pos Traumatic Stress Disorder (PTSD);
[6]Agoraphobia and Social Phobia;
[7]Schizophrenia, Delusional Disorder, Acute Psychotic Disorder, Schizoaffective Disorder, Severe Depression, and Bipolar Affective Disorder.
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was 69.6% [18]. However, differently than in our study, lifetime prevalence rates higher than 80% have been reported among men [19] [20] [21]. This may be due to the fact that personality disorders were excluded from our study.

In the current study, the lifetime and 12-month prevalence rates of mental disorders were, respectively, 1.2 and 1.8 times higher among women than among men. More psychiatric morbidity among women prisoners has also been reported by other studies [22,23]. Women are in general less likely to commit crimes, although those who commit are usually characterized by a psychopathological profile [6].

We also found that the anxious-phobic disorders were the most prevalent among prisoners, differently from other studies in which drug-related disorders were the most frequent. Nevertheless, anxious-phobic disorders have been reported as one of the most common mental disorders [21] [20] [19].

Anxious-phobic Disorders

The high rates of anxiety-phobic disorders observed can be explained by the high prevalence rates of PTSD. Varying prevalence rates of PTSD were found among prisoners from other countries [20] [24]. In Spain, the lifetime and 12-month prevalence among men (3.5% and 0.4%) were lower than those found in this study (26.4% and 7.8%) [20]. In Australia, the 12-month prevalence rate was 25%, for both men and women. The high prevalence found in this country was attributed to the high number of stressors and traumatic events associated with imprisonment butler [24]. In São Paulo, PTSD rates may also be influenced by the instability of the prison system, which is subject to rebellions as previously mentioned.

Other studies have reported prevalence rates of generalized anxiety disorders higher than those described here [1] [25]. The exception was the study carried out with male prisoners in Iran, which identified a 12-month prevalence rate of 5.7% [21].

Affective Disorders

Affective disorders were the second most frequent mental disorder among prisoners, with emphasis on depressive disorders. Similarly to data reported for the general population, affective disorders were three times more prevalent among women than among men. Gender-related differences in the prevalence of affective disorders have been poorly studied in the prison population, with the exception of a Canadian study, which identified a female to male ratio of 1.3 [18].

The lifetime and 12-month prevalence rates of affective disorders among men were lower than those reported by other studies [20] [21] [1], with the exception of the study conducted in Italy [19].

For both genders, the prevalence rates of depressive disorders were lower than those reported in the literature [20] [1] [25].

The prevalence of affective disorders should be analyzed carefully because the conditions of imprisonment, together with the absence of standardized diagnostic criteria, may lead to an overestimation. Incarceration may trigger symptoms similar to depression such as acute stress, grief, derealization, sleep disturbances, loss of interest and energy, low self-esteem, worrying, and anxiety [9].

Drug-related Disorders

For both genders, the lifetime prevalence of drug-related disorders was higher than those reported by studies performed in the general population [14] [13]. Unlike those, which have shown higher rates of drug-related disorders among men, we found no gender-related differences.

In general, the rates of drug- or alcohol-related disorders were lower than those found in other studies of prison populations [26] [20].

The differences in prevalence found in the studies may be explained by the particularities of each country, such as the criminalization and the cultural pattern of drug use [23], and the access to these substances in prisons [9]. The low prevalence rate found in our study may be associated with the controlling role played by organized groups of inmates. These groups were created in the prisons of São Paulo to regulate coexistence among inmates with the purpose of self-protection [27]. The consumption of hard drugs, because of its destabilizing character, may have required stricter disciplinary codes imposed by these groups, resulting in reduced drug use.

Severe Mental Disorders

The high prevalence rates of severe mental disorders among prisoners contrast with estimated general population rates. While rates vary between 0.4% and 7.7% in the general population [28], we found 12-month prevalence rates of 14.7% and 6.9% among women and men prisoners, respectively. These results are similar to those of other studies of prison populations. Some type of severe mental disorder was found in 15% of women and 5% of men in prisons in New York City [29], and in 17.7% of women and 7.8% of men in prisons in Florida, USA [30].

The clinical conditions associated with severe mental illness are chronic and may constitute a risk of suicide and significant psychosocial damage, requiring specialized services [18]. Moreover, these inmates are frequent victims of discrimination and humiliation and may pose a risk for the stability in the prison given the behavioral changes associated with psychiatric disorders [31].

Psychiatric Comorbidity

We found high rates of psychiatric comorbidity, particularly among women prisoners. These results agree with those of other studies, which have shown rates from 50% to 90% [6]. The high rate of comorbidity, which has been linked to the violent and offending profile of inmates [21] [26] [20], reinforces the impact and severity of mental disorders in prisons.

Penitentiary System

Similarly to other studies, we found that severe mental disorders, alcohol-related disorders, and depression were more frequent among prisoners in temporary regime (TDC) than among those in closed regime (prisons) [6]. The prisoner under a temporary regime is usually waiting to be transferred to a prison. Thus, this difference in prevalence may be due to the transfer of prisoners to psychiatric treatment centers instead of to prisons [9]. On the other hand, the fact of being under a temporary regime may be very distressing due to several destabilizing experiences, such as the new condition of being incarcerated, the fact of having to deal with judicial processes and uncertainties about the future [31].

Issues of Incarceration

The main causes that explain the high prevalence of mental disorders in prison populations are the stressful conditions imposed in the execution of the sentence and prior morbid conditions that make people more likely to commit crimes [32].

Regardless of whether mental disorders are the cause or consequence of the prison, the conditions of imprisonment with its inherent stressors do not contribute to preserving mental health and do not favor the treatment of individuals with more severe or chronic mental disorders [24]. Furthermore, the prison systems do not always have adequate resources for health care. Complicating factors for the evaluation and treatment of mental disorders in prison have been identified, such as the limited validity of the records and observations on prisoner admission, inadequate transmission of information between prison professionals, identification of certain symptoms (e.g., anxiety and aggression) over others (e.g., depressive or psychotic symptoms) and the absence of tools to support diagnosis [18].

The prisoners may not recognize their own illness, and thus fail to seek psychiatric treatment. This fact impairs initiatives towards promoting mental health and treatment in prison. In this study, we observed very low rates of self-reported mental disorders (4.0% among women, 3.3% among men), which may be explained by insight impairment, by the stigma associated with mental illness and by the fear of being transferred to custodial hospitals [19].

Based on this information, measures to improve health conditions of prisoners have been proposed. They include improved screening methods for mental disorders, prison staff training, reducing the ratio between officers and mental health professionals and prisoners, confining one prisoner per cell, increasing encounters between prisoners and their families, offering educational programs, work and exercise in prisons, and applying policies against sexual assault, among others [2].

Conclusions and Recommendations

This is the first large-scale epidemiological study performed with the prison population in Brazil, revealed high rates of psychiatric disorders among men and women. Many similarities, as well as some differences, were found between our results and those of studies conducted in other countries. The differences observed are more likely due to the peculiarities of the prison systems in each country than to the diagnostic criteria adopted in the studies. This fact reinforces the importance of conducting such studies as part of planning and development of appropriate policies for the particular mental health needs of specific prison populations.

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Author Contributions

Conceived and designed the experiments: SBA MIQ WSR SLB JGVT JJM. Performed the experiments: SBA MIQ WSR. Analyzed the data: SBA MMS MIQ WSR SLB. Contributed reagents/materials/analysis tools: SBA MMS MIQ WSR SLB. Wrote the paper: SBA MMS MIQ SLB JGVT JJM.

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