ORIGINAL ARTICLE

The role of national policies and mental health care systems in the development of community care and community support: an international analysis

Frank van Hoof[1], Aafje Knispel[1], Jørgen Aagaard[2], Justine Schneider[3], Chris Beeley[3], René Keet[4], and Marijke van Putten[4]

[1]Trimbos Institute, Netherlands Institute for Mental Health and Addiction, Utrecht, the Netherlands, [2]Centre for Psychiatric Research, Aarhus University Hospital & CSU, Aarhus Municipality, Aarhus, Denmark, [3]Institute of Mental Health Nottingham, Nottingham, UK, and [4]GGZ Noord-Holland Noord, Heiloo, the Netherlands

Abstract

Background: The development of adequate community support of persons with severe mental health problems is an ongoing effort. National policies and national health and social care systems play an important role in the effectiveness of these efforts.
Aims: To get a better understanding of the ways in which national policies and (mental) health care systems can enhance the development of community support and social inclusion for people with severe mental illness.
Method: A comparison was made between the experiences of 75 key persons on regional community support development regarding national policies and systems in Denmark, England and the Netherlands respectively.
Results: Four themes stood out as being particularly instrumental in the development of community support: – implementation of a national policy on social inclusion, – development of a national framework of responsibilities, entitlements and services, – solid funding and social inclusion incentivizing reimbursement systems, – integrated care.
Conclusion: National governments do have opportunities to take or retake the lead to ensure that community support and social inclusion of persons with severe mental illness health problems are not just ideological slogans but solid policy.

Background

The development of adequate community support services for persons with severe mental health problems is an ongoing effort. Previous studies have highlighted the importance of national policies and national health and social care systems in the effectiveness of these efforts (Goldman, 1998; Goldman et al., 1995; Knapp et al., 2007a,b; McDaid, 2005; Sayse & Curran, 2007);. These policies and systems differ across countries and change over time. Especially in times of economic crisis, there is a challenge in keeping social inclusion and community support of persons with severe mental health problems on the national policy agenda (Knapp et al., 2009). Therefore, it is essential to further develop a proper understanding of what constitutes ''good'' national policy, given national contexts and changes over time.

Aim

The aim of this study is to get a better understanding from a local and regional experiential base of the ways in which national policies and (mental) health care systems can enhance the development of community support and social inclusion for people with severe mental illness. In this study, social inclusion is being defined as the extent to which people are able to exercise their rights, to participate, by choice, in the ordinary activities of citizens in the society in which they reside and to shape all aspects of their life (health, social relations, housing, daily activities such as work and education), according to their preferences and as they see fit. Community support is being defined as those services and conditions that are necessary to enable social inclusion (Mental Health Commission, 2009; Van Hoof et al., 2011).

Methods

The issue of national policy on social inclusion and community support was investigated through an empirical study of the perspectives of key persons in three leading regions in

Correspondence: Frank van Hoof, Trimbos Institute, Netherlands Institute for Mental Health and Addiction, P.O. Box 725, 3500 AS Utrecht, the Netherlands. Tel: +0031 30 2959365. Fax: +0031 30 2971111. E-mail: fhoof@trimbos.nl

Denmark, England and the Netherlands. The three centres – Aarhus, Nottingham and Alkmaar – are all considered to be relatively innovative and at the forefront of developments in community support in their respective countries. Concentrating on Denmark, England and the Netherlands, the study provided the opportunity to analyze experiences and views in countries which are relatively comparable in relation to health, income and cultural standards, but differ considerably in deinstitutionalization history (Priebe et al., 2008) and in national mental health and community support policy and system characteristics.

Study participants

The key persons who participated in the study were all experienced professionals, users, managers and commissioners in one of the regions and were closely involved in local developments in long term mental health care, housing, education, vocational services or the organization and financing of services for persons with severe mental health problems. In total, 75 regional key informants participated in the study.

Data collection and analyses

Data on the respective national policies and systems were gathered through desk research using a snowball method and starting with Medline and PsycINFO searches and documentation that was introduced by key-experts on health care

systems and community care in each of the three countries. Data on experiences with community support incentivizing or inhibiting characteristics of the respective national policies and systems were gathered through individual telephone interviews with the key persons in the three regions. The interviews focused on two questions:

(1) In the past decade, what aspects of national policy and national mental health systems helped or hindered the development of community support for persons with severe mental health problems in the region?
(2) Concerning the future, what would constitute as good national policy and a good national system for the (further) development of community support?

The interview reports were analyzed by going through the steps of structuring, labeling and exploring the connections (grouping patterns) between the labels. Results were validated in a series of nine group interviews with the key informants, three in each region.

Results

National policies and mental health care systems in Denmark, England and the Netherlands

Figure 1 shows the past decades policy and system characteristics concerning mental health care and community support for persons with severe mental health problems in Denmark, England and the Netherlands on a number of important parameters.

Figure 1. Main policy and system characteristics in Denmark, England and The Netherlands.

	Denmark	England	The Netherlands
Capacity of clinical and residential services			
Psychiatric beds	Low	Low	High
Residential services	High	Low	High
Mental health care system			
Centralized versus decentralized	Decentralized	Centralized	Decentralized
Public service versus market oriented	Public service	Public service	Market
Regional organization	Yes	Yes	No
National policy			
Attention to community care and support	Average	High	Low
Attention to social inclusion	Average	High	Low

Policy and system in Denmark

Mental health care in Denmark consists of two relatively independent sectors. Regional health authorities control the psychiatric hospitals and psychiatric services specialized in out-patient care. Responsibility for social psychiatry and for residential care lies with the municipalities as do support services in the fields of day-activities, employment and education. Health care in Denmark is mainly financed through national taxes but regional and local authorities decide for themselves which part of their health budgets will be spent on mental health care services. In the past, several specific incentives have been created on a national level to promote community support and social inclusion. For example, local authorities have to pay for prolonged hospitalization when adequate social psychiatric or local residential care is not available. In addition, there are some obligations for the two systems to cooperate on an individual service level as well as on an aggregated service planning level. Also, Danish national legislation entitles all disabled adults, including persons with severe and persistent psychiatric disorders, to education or vocational training. Furthermore, about 1/4 of the apartments in subsidized housing are reserved for persons with social or mental health problems.

Policy and system in England

Unique to the English situation is the fact that community mental health services have been developed as a result of a stringent, prescriptive national policy, implemented in the 90s. These services are provided by regionally organized, ''statutory'' mental health care trusts that are part of the National Health Service (NHS), a publicly-financed health care system, under direct control of the Department of Health. Social support in the areas of housing, social contacts, education and work is also partly offered by the mental health care trusts. However, important in this area are also the services of ''non-statutory'' (or ''voluntary''), organizations, that draw their income from a broad range of sources. In the past decade the development of these non-statutory social services has been stimulated by central government policy. Also during the past fifteen years, national policy regarding mental health care has evolved from the prescriptive approach on the desired community mental health care structure, to a broader promotion of social inclusion and recovery objectives.

Policy and system in the Netherlands

Developments in the organization of community support in the Netherlands have mainly been the result of initiatives within the field of mental health care itself. As a result (and in contrast to England) the Netherlands do not have a centrally-organized structure for community care. Also (and in contrast to Denmark) regional and local authorities have so far hardly played any part in the design and organization of community support in the Netherlands. Since 2008, private health insurers control and allocate the largest part of the mental health care budget. From then, there is no overarching structure for service planning on a regional level anymore. As the high levels of inpatient and residential capacity show, there has

traditionally been relatively little national policy attention to community support. Only recently, the subject of social inclusion has re-emerged on the agenda of the national government, especially in relation to new targets for bed reduction.

Field experiences and views on the incentives and impediments of national policies and systems on the regional development of community care and community support

The impact of national policies and systems on the development of community care and community support services was studied from the perspectives of key persons in three leading regions: Aarhus, Nottingham and Alkmaar. In Aarhus, it is particularly the municipality which has always played an active role in the support of vulnerable citizens, among them persons with severe mental health problems. Nottingham is the home of some of the most influential consumer organizations and consumer representatives in England. In Nottingham the psychiatric bed capacity is even lower than the national average in England. In the Netherlands, Alkmaar is known as a pioneer in bed reduction and the development of community alternatives, especially in the form of FACT – Flexible Assertive Community Treatment, a model for integrated and flexible care that is gradually spreading across the country.

Experiences and views of key persons in Aarhus – Denmark

Key persons in Aarhus appreciate the national de-institutionalization process from the past and the recommendations in more recent policy documents in Denmark for social inclusion and for cross-sector co-operation in attaining that goal. Although a comprehensive national implementation plan has never been developed, some concrete national measures have helped progress on a regional level, including the introduction of entitlements in the field of work, education and housing and the mandatory co-operation at both an individual and a regional level.

Most typical for the Danish system is the dual mental health care system and the prominent role of municipalities. According to many, making municipalities responsible for social psychiatry unmistakably increased the opportunities for local co-operation with other relevant municipal departments (education, housing, work). It also helps to inhibit the ''medicalization'' of problems and to put social inclusion and recovery more explicitly on the local agenda. On the other hand, the dual system can hinder the continuity of care. Some interviewees express concerns about the respective systems drifting apart, resulting in risks for integrated care and in people falling between two stools.

Among the informants, there is also some ambiguity about the fact that the responsibilities for budget allocation and service planning have been largely decentralized. This decentralized system can offer opportunities for innovation in times of prosperity, but it also appears to undermine the maintenance of the level of services in more economically difficult times. Also, the decentralized system results in substantial variation in service levels between regions.

Experiences and views of key persons in Nottingham – England

Of the three regions, key persons in Nottingham are the most positive about the incentives from national policy of the past decades on the development of community care and community support for persons with severe mental health problems. They are also the most concerned about the future.

According to the interviewees, the formerly-prescriptive national approach did pay off in a solid national structure for long term community care. Supplementary programs of innovation in the fields of ''supported housing'' and ''supported employment'' are also said to have been successful during the past decade, especially due to the combination of ring-fenced budgets and the awarding of funding conditional on local co-operation. Key persons in Nottingham also believe that the prominent place of themes of ''social support'', ''recovery'' and ''social inclusion'' in the leading national policy documents of the past few years, helps to create the right ''mind-set'' on a regional level and to gain broader attention in (regional) society for the position and experiences of persons with severe mental health problems.

Meanwhile, there are great concerns about the future. These concerns stem from three factors. The first is that the more recent policy intentions about social inclusion and recovery lack the solid implementation plans of earlier national policy objectives. Secondly, the socially-oriented and participation-oriented facilities for persons with severe mental health problems lack the relatively solid financing of the health care system and have been under a great deal of financial pressure in the past few years. Thirdly, according to interviewees, recent national reform plans, aiming at transferring responsibilities for health care and social care to the local level and to the market, might increase the vulnerability of many social support services.

Experiences and views of key persons in Alkmaar – The Netherlands

As compared to key persons in Aarhus and Nottingham, those in Alkmaar are clearly less positive about the contribution of Dutch national policy and system characteristics to the development of community care and community support in the region. In the past decades the national government has not been a frontrunner in enhancing community support and social inclusion of persons with severe mental health problems in the Netherlands. Also high institutionalization rates have long been taken for granted. Organizations that did wish to deinstitutionalize faced financial risks.

Meanwhile, there are concerns about the tendency of community care and community support funding getting spread over several funding systems, controlled by private and local agencies. As a result of this fragmentation and decentralization, there is an increasing sense, both nationally and regionally, of a lack of a clear line of responsibility for the realization of the required services network. At the same time, co-operation is impeded by the new health systems incentives for competition between providers as well as between funding agencies.

Against this background, the renewed national policy attention for psychiatric bed reduction is viewed with some ambivalence. It is questioned whether the decentralized, competitive health care system and the non-ring-fenced municipal social care system will offer sufficient guarantees that community alternatives will be developed for the inpatient services that are tear down.

Different policies and systems, congruent views on barriers and aspects of effective policies and systems

Key persons in all three regions believe that a good base for community care and community support has been built in their regions. Directive national policies and innovation programs in the past have especially been experienced as helpful in England. In Denmark the dual mental health system together with the obligation of joint service planning, ensured that municipalities are closely involved. In the Netherlands the development of community care and community support has mainly been an enterprise of and within the mental health care field itself.

In each of the three regions, key persons also believe that there is a big potential for the further development of effective and comprehensive community support systems. The analyses of the interviews disclose that there is a fair amount of congruence between the countries concerning current impediments and challenges. The common challenges are twofold and have to do with the inherent characteristics of the deinstitutionalization process itself on the one hand, and with some current political-administrative developments on the other. Inherent challenges lie in the fact that de-institutionalization brings about an expansion of interest groups, sectors and funding agencies involved, resulting in a diffusion of responsibilities, resources and entitlements. Related challenges lie in the vulnerability of community support services that span health and social care systems and the tension between the ambition to involve the wider community and the ambition for coherent and integrated care (McDaid et al., 2007; Medeiros et al., 2008).

On a political-administrative level, the main common challenge is the fact that each of the three countries witnesses a tendency to decentralize responsibilities to local politics (with Denmark as a frontrunner) and to introduce market incentives and private providers and funding agencies (with the Netherlands in the lead). This combination of inherent deinstitutionalization challenges and political-administrative trends raises concerns that, while diffusion of responsibilities calls for strong incentives for cooperation, system developments might just make individual interests of providers and funding agencies drift away from common interests of the social inclusion of persons with severe mental health problems.

National policy and system requirements

In response to these challenges and concerns, key persons in all three regions call for an authoritative advocate and organizer of community support and social inclusion on a national government level. Main requirements of a promising

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national policy and service system, as suggested by key persons, can be clustered into the following four groups:

National policy vision on social inclusion

Key persons call for a genuine acknowledgement and promotion of the social and economic benefits of community support and social inclusion of persons with severe mental health problems on a broad, cross-departmental national government level.

National framework of responsibilities, entitlements and services

Key persons promote the development of a national framework, defining responsibilities of national, regional and local authorities and other relevant agencies (commissioning and funding agencies), concerning community support services and social inclusion of persons with severe mental health problems. In particular, the responsibility for coordination should be addressed. Also, the entitlements of individuals with severe mental health problems in the fields of housing and work should be made explicit.

Structural funding and inclusion incentivizing reimbursement systems

A widespread view among key persons in all three regions is that implementation of community support and social inclusion policies calls for a solid, structural and ring-fenced funding and adequate financial incentives. The attainment of flexible, long-term and coherent individual support in independent living, social contacts, education and employment requires a solid (possibly joint interdepartmental) funding that is ring-fenced and structural. Reimbursement systems based on psychiatric diagnoses and impairments should be replaced by systems that reward adequate community care, a recovery-approach and strong local cooperation and partnerships in funding and service provision.

Integrated care for the most vulnerable clients

Interviewees also expressed that possibilities should be explored to create integral budgets across sectors and funding systems for integrated support for the most vulnerable clients among the population of persons with severe mental health problems.

Discussion

The three regions in this study are all considered to be relatively innovative and at the forefront of developments in community support in their respective countries. This might have affected the outcomes of the study. Specifically outcomes may be more outspoken then would have been the case if less ambitious regions would have been selected.

Given this limitation, the results of this study suggest that, from an operational, regional perspective, the development of an adequate community for persons with severe mental health problems calls for a strong national government policy. This raises the questions whether we might expect this need to be met in times of decentralization and privatization. And, if not,

what would be the case for national government involvement in mental health policy and planning?

One important argument would be that, if private providers and funding agencies, alongside local authorities, are expected to take a lead in the further development of community support services, the national governments may be expected to create the conditions in which:

- Community care is more remunerative than inpatient care;
- Participation and recovery-oriented care is more remunerative than medicalizing care;
- Co-operation is more remunerative than individualism;
- Taking responsibility is more remunerative than shifting it to others;
- Quality improvement in support services for ''difficult'' groups is more remunerative than tapping new markets.

In actual policy practice this approach requires the development and implementation of financial incentives that facilitate, stimulate and support the desired outcomes as mentioned above. Important to note, however, is that in the transition to a more decentralized and privatized public services system, this field of incentivization is still relatively underdeveloped, and untried. In practice a broad range of measures will be required, accounting for the context in which these measures are implemented and for the fact that effects depend on the interaction of several variables, including the design of the intervention (e.g. who receives payments, the magnitude of the incentives, the targets and how they are measured). In this respect, it will be especially important to further develop our understanding of effective incentivizing measures and methods in the field of community support for persons with severe mental health problems.

It is beyond the scope of this article to specify in detail the consequences of this policy and research requirements. Our conclusion remains that a strong national government policy is essential, also when current political-administrative developments ask for new national policy strategies. Exploration in theory and practice of these new strategies should be high on the research agenda for the next decade.

Conclusion

National policies and national health and social care systems play an important role in the development of adequate community support for persons with severe mental health problems. Key persons in community support developments in Aarhus, Nottingham and Alkmaar appreciate their respective national policies and systems differently. However, in each of the three regions, key persons also believe that there is a big potential for the further development of effective and comprehensive community support systems. There seem to be two common challenges in that. The first is that de-institutionalization brings about an expansion of interest groups, sectors and funding agencies involved, resulting in a diffusion of responsibilities, resources and entitlements. This calls for strong incentives for cooperation, continuity and coherence in service provision. The second is that each of the three countries witnesses a tendency to decentralize responsibilities to local politics and to introduce market incentives and private providers and funding agencies. This creates new

opportunities; but it also creates an extra challenge in aligning individual interests of separate, competitive providers and funding agencies with the common interest of investments in cooperation in the community support of persons with severe mental health problems.

According to the key persons, the development of adequate community support calls for a authoritative advocate and organizer of community support and social inclusion on a national government level. Main requirements of a national policy and service system are:

- A national policy vision on social inclusion;
- A national framework of responsibilities, entitlements and services;
- Structural funding and inclusion incentivizing reimbursement systems;
- Integrated care for the most vulnerable clients.

Declaration of interest

The authors declare that there are no conflicts of interests. The authors alone are responsible for the content and writing of this article.

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