

Outpatient care and community support for persons with severe mental health problems

A comparison of national policies and systems in Denmark, England and the Netherlands



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A comparison of national policies and systems in Denmark, England and the Netherlands

Trimbos-institute,
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Since 2008 the Trimbos-institute publishes annual trend reports on the developments in mental health care. The reports are commissioned by the Ministry of Health Care and Sports of the Netherlands. The primary aim is to give a survey of the relevant developments (for national government policy) in the field of mental health care. The reports have a signaling, an analyzing and an evaluating function. Except for the national authorities, the reports are also for the use of others involved in mental health care and mental health policy, among which policy makers of providers, funding agencies, umbrella organizations and client organizations.

The annual trend reports cover three areas:

- Organization, structure and financing of mental health care
- Access to and use of mental health care
- Quality and effectiveness of mental health care

Every two year, overview reports are written on each of these areas. In the intermediate years special issues about current themes are published. This report is the second special issue in the area Organization, structure and financing of mental health care.

Many people contributed to this report, either by giving an interview or advice or otherwise. We are very grateful to them. The responsibility for the contents exclusively rests upon the authors.

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Summary

This report describes the results of an international comparison of the incentives and disincentives of national policies and funding systems on the development and implementation of comprehensive community support services for persons with severe mental health problems. These relationships were studied from the perspective of three mental health care regions in Denmark (the Aarhus region), England (the Nottingham region) and the Netherlands (the Alkmaar region) respectively. The regions that participated in the study are seen in their respective countries as good practices concerning community support for persons with severe mental health problems. Key persons operating in the respective regional networks of care and support services for persons with severe mental health problems, were the main information source on incentives and disincentives of national policies and systems.

National systems and policies in Denmark, England and the Netherlands

The study shows that there are similarities but also some important differences in the Danish, English and Dutch national policies and national service systems regarding community support and social inclusion of persons with severe mental health problems. Similarities are in the fact that in all three countries some form of regional or local organization of community support prevails and that local or regional mental health care organizations play a crucial role in these regional systems. Also, in all three countries these mental health care organizations are not exclusively oriented on community care and community support for persons with severe mental health problems. They provide the full scope of mental health care services to persons with severe and mild mental health problems (inpatient, residential and outpatient services). In addition, in all three countries *community care* (or mental health home care) can be considered an element of the national health care system and of the services of the mental health care organizations. As *community support* (services aiming at social participation and social inclusion) is concerned, more actors and more funding systems come into play, especially local actors and most of the time also funding systems with a more prominent role for local parties.

One of the main differences between the three countries is the level to which mental health care has been deinstitutionalized in the past decades. Deinstitutionalization and the development of community care have been very explicit policy goals in England and in Denmark. Specifically in England the development of community care for persons with severe mental health problems has been enforced by an explicitly prescriptive national policy. To a lesser extent the same is true for Denmark. In the Netherlands,

incentives for deinstitutionalization and for the development of community care have been much more non-committal and have in fact faded out since 2002. As a result, the Netherlands stand out with a very high number of psychiatric beds and residential facilities, while inpatient and residential capacity in England is one of the lowest in Europe. Denmark holds a position in the middle, with relatively low psychiatric inpatient capacity and high residential capacity (sheltered housing, nursing homes).

When community care (aimed at home care instead of inpatient care) is considered as a first step and broader community support (aimed at participation) as a second step towards social inclusion, again especially England has made some further moves in recent years, at least in national policy vision and statements. Social inclusion and involvement of a wider society in the community support of persons with mental health problems is at the core of recent English policy documents. Several innovation programs and national campaigns have supported these policies. Also in Denmark, social inclusion has grown into a central issue in policy documents. Several measures have been taken to arrange individual or group entitlements on work, education and housing and to promote cooperation between relevant providers. In the Netherlands, downsizing inpatient capacity has grown into a national issue only recently. No specific targets or social inclusion policy plans or measures have been formulated yet.

The three countries also differ with respect to their general (mental health) care systems, especially concerning levels of centralized or decentralized administrative control, levels of market incentives and involvement of local authorities. England traditionally has the strongest nationally controlled system, characterized by a prescriptive policy concerning availability and organization of services. Also commissioning and funding in England has for a long time been mainly through (representatives of) national authorities. In Denmark and in the Netherlands, responsibilities and control are more decentralized to regional and local authorities and to health insurers respectively. The level to which market incentives have been introduced is the largest in the Netherlands, where competing private health care companies contract services from competing (mental) health care providers. As the involvement of local authorities is concerned, Denmark stands out with social psychiatric care and housing being funded and controlled almost fully by local authorities since the Structural Reform of 2007. In the Netherlands local authorities hardly come into the mental health care picture at all. In England the role of local authorities is in a position in between: local authorities do provide social services for persons with severe mental health problems but social psychiatry as such is still part of the health care system and the mental health care providers. Specific to the English system is also the involvement of so-called non-statutory, third sector organizations in the fields of housing, community support and participation. These organizations derive their income from a range of (often temporary) local and national, public and private sources.

Remarkably, while levels of central control and prescriptive policy, market incentives and local authority involvement greatly differ across the three countries, a partly ideologically motivated convergence seems to be taking place lately in all three aspects. In England reform plans are to transfer national responsibilities to the local level, introduce market incentives and increase involvement of the private sector. In the Netherlands, market incentives and private health care insurers already have a prominent role. However, local authorities were hardly in the picture until recently but will be in the near future, as a result of the transfer of responsibilities from the health care funding system to the locally administered Social Support funding system. In Denmark, decentralization of responsibilities and especially transfer of services to local authorities has moved the farthest. Introduction of market incentives is not so much a national policy as well as a probable result of the decentralized system on a local level.

Community care and community support in Aarhus, Nottingham and Alkmaar

Services for persons with severe mental health problems in each of the three regions reflect national systems and policies but also have their own characteristics and even similarities. Specifically, compared to national standards, all three regions have a relatively long-standing ambition of developing adequate community support services for persons with severe mental health problems. All three regions have developed a range of community support services and put efforts in local coordination of these services on an individual and organizational level. Also the recovery approach has been adopted by the relevant organizations in Aarhus, Nottingham and Alkmaar and implementation programs are running in each of these organizations.

Main differences between the regions can be found in capacities, the role of the mental health care system and the involvement of local authorities. Comparing total inpatient and residential facilities of the three regions, Nottingham's capacity is by far the lowest. In contrast to national figures, not Alkmaar but Aarhus has the highest capacity (due to a relatively large capacity of residential facilities in Denmark and especially in Aarhus). Alkmaar also stands out with an all-embracing role for the regional mental health care provider (partly as a result of the Dutch mental health care system and notwithstanding ambitions to involve the local community). Local authorities hardly come into play in Alkmaar. In Aarhus the situation is almost the other way round, with in fact two mental health care systems – run by the Aarhus University Hospital and the municipality respectively. Traditional mental health care, as represented by the Aarhus University Hospital, plays a relatively small role in community support while municipal social psychiatric services are much more important, alongside other municipal services in the field of housing and participation. In this respect, Nottingham holds a position in the middle, with community care mostly provided by several teams of the main regional local mental health care provider, but where non-statutory organizations and local authorities also provide services to persons with severe mental health problems.

None of the three regions has comprehensive and representative data on the actual quality of services and quality of life of persons with severe mental health problems in the region. Still, in all three regions key persons believe that a lot of progress has been made in the past years and decades in the development of regional community care and community support services. Also in all three regions key persons believe that there is still a lot to be done. Especially the persistent dominance of symptom- and impairment-oriented psychiatric perspectives and practices in mainstream regional mental health care is still considered a very important barrier. Stigma is another one, especially stigma in the mental health care system itself. Anti-stigma campaigns but also education of mental health care staff are crucial in this respect. Key persons in Aarhus, Nottingham as well as Alkmaar have high hopes of the new recovery-approach and recovery-education programs, although some also mention the risk of recovery turning from the original consumer-led emancipation perspective into yet another professional mental health care method. In this respect, not so much consumer involvement, but consumer control and genuine, open encounters between persons with severe mental health problems, professionals and other members of the local community, are said to be crucial for future developments on an operational level.

Perspectives on national incentives and disincentives for community support

Next to these regional concerns, key persons in all three regions mention a range of past and current incentives but also impediments to the development of community support on a national policy and system level.

Key persons in Aarhus in general appreciate the past emphasis on deinstitutionalization and the recent pleas for social inclusion and cooperation in national policy documents. Many believe that regulations for individual and group entitlements for persons with mental health problems in the fields of work, education and housing have been to a certain extent effective. That is also the case for the several instruments in the Danish system to promote cooperation on an individual and regional level. Key persons in Aarhus are more ambiguous about the dual mental health care system. According to some, the transfer of social psychiatry to the municipality has increased chances for local cooperation with other relevant municipal departments (education, housing, work). However, the dual system is also believed to hinder integrative, comprehensive and continuous care. Concerns are that the gaps between the respective systems and services will grow wider, integrated services will become harder to realize and especially the most vulnerable people will fall through the cracks. Alleged incentives for a shift of attention away from persons with the most severe mental health problems enforce these concerns. Another national policy barrier to the further development of community support or even the continuation of existing services is that decision making on budgets and required services is to a great extent decentralized to the regions and the

municipalities. This can be a potential for innovation in prosperous times, but is at the same time proving to be a great risk in current times of economic crisis, as budget cuts are especially taking place in the municipalities' support services.

Of the three regions, key persons in Nottingham are the most positive about the incentives of past national policies on the development of community care and community support for persons with severe mental health problems. Especially the directive approach through clear funding criteria (in structural funding as well as in temporary innovation funds) is believed to have paid off and has helped create an adequate and solid national structure of community mental health care. Success of additional innovation programs in the fields of (supported) housing and employment was due, according to key persons, to the combination of solidly ring-fenced (cross-departmental) budgets with the funding requirements of local partnership. Key persons in Nottingham also believe that the policy objective of community support has gained content by more recent national policy documents on social inclusion, recovery and the involvement of the educational and employment sectors. Key persons also mention several barriers in national system and policy characteristics, however, of which some are long-standing and some are new. As a main barrier to the further development of community support, key persons point at the vulnerability of the fragmented and non-structural funding of (the partly non-statutory) community support services in the fields of supported housing, social contacts, day-activities, education and work (as opposed to the much more solidly structured and funded community care teams). Nottingham currently witnesses severe budget cuts in this area. Key persons in Nottingham also believe that the recently developed national policy goals of social inclusion and recovery help create the right mind-set, but lack the solid implementation plans that accompanied the earlier development of the community care teams. Concerns are especially expressed that the vulnerability of community support funding for persons with severe mental health problems will in fact be increased by current policy plans to transfer responsibilities to the local level and to the market.

According to key persons in Alkmaar, the development of community care and community support in the region has benefitted from several national innovation programs throughout the years. However, the impression is that the overall contribution of national policy and system characteristics to the development of community support for persons with severe mental health problems in the Netherlands and in Alkmaar in the past decade has been very modest. At the same time, there have been and still are some specific barriers. As comments on national policies from the Nottingham and Aarhus regions mainly focus on the vulnerability of existing *community support services*, key persons in Alkmaar believe that barriers in the Dutch system and policy first of all concern the previous step: the transfer of inpatient capacity to *community care*. Throughout the years and until now the mental health care funding system is characterized by positive incentives for inpatient and residential care. At the other end of the scale are high economic risks for organizations that try to deinstitutionalize and obtain

inclusive policies. Also administrative procedures for funding of support trajectories in the field of day activities, education and employment, are very time-consuming, more so because these procedures have to be followed for each individual trajectory. In general, the organization of comprehensive and coherent support for persons with severe mental health problems is believed to be hindered by the fact that these support services and even mental health care services alone are dependent on a range of funding systems. This fragmentation of funding systems is mirrored in the diffusion of responsibilities on a regional and national authority level, resulting in a lack of a key problem owner and a lack of coordination and planning. In this context, the renewed attention on a national policy level for psychiatric bed reduction and the transfer of responsibilities to local authorities is received with ambivalence. More so because neither the decentralized, competitive health care funding system nor the non-ring-fenced social support funding system of the Social Support Act, offers guarantees that alternatives will actually be developed for the services that are being broken down.

Conclusions

Key persons in the three regions believe that a good base for community care and community support has been built in Aarhus, Nottingham and Alkmaar respectively. Directive national policies and innovation programs in the past have especially been helpful in England and to a lesser extent Denmark. Key persons also believe that there are good (economic) arguments and a big potential for the further development of effective and comprehensive community support systems. However, this development currently seems to be frustrated in all three regions by some old and some newer policy and system barriers. In part, these barriers again differ across the countries, with the Netherlands standing out for its strong, although unintended financial incentives for inpatient care and against integrated community care. But there is also a lot of congruence between the countries concerning current impediments.

In short, these common impediments are about the vulnerability of community support services between health and social care systems, the lack of ring-fenced budgets, the lack of key problem ownership and the tension between the ambition to involve the wider community and the ambition for coherent and integrated care. In addition, concerning recent policy developments, 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 parties (with the Netherlands in the front). Specifically this combination of developments is considered a risk for the further development and even continuation of existing community support services. The reforms might result in a (further) diffusion of responsibilities and, even more important, in individual interests drifting away from the general social and economic interest of social inclusion, thereby discouraging investments in the further development of local community support systems and in cooperation and coordination.

Currently public expenditure cuts already find an easy way to community support services for the (mostly relatively non-assertive) population of persons with severe mental health problems (especially in England, but also in Denmark and the Netherlands). This entails a great risk of frustrating and even turning back a range of hopeful developments on an operational level. In the end, it might result in a lower participation of persons with severe mental health problems in society and in higher costs of care and costs of social benefits.

Recommendations

According to key persons, social inclusion is the only sustainable answer to economic costs of severe mental health problems. This makes the urgency of investments in the development of well-organized and solidly funded community support systems even greater in times of economic recession. Also, according to key persons, the national, social and economic importance of good support and social inclusion of people with severe mental health problems requires an authoritative advocate and organizer on a national government level. The scope of this advocate should transcend individual levels of influence and current individual interests of providers, local authorities, private parties, commissioning agencies and separate ministries. This national advocate should join forces with all relevant parties to develop an integrated and intersectoral national policy that defines values, direction, responsibilities, structure and funding of services. It should especially define what is necessary to bring individual interests of relevant parties in line with the general interest of social inclusion. In this way it should facilitate, stimulate and, where necessary, structure community support and social inclusion of persons with severe mental health problems.

Some elements of such a national policy are already present in the three countries, although to a different degree and in different respects. But in all three countries there is also still a lot to be won in terms of comprehensiveness, coherence, directiveness and implementation of national social inclusion policies. Key persons in the regions have made a range of suggestions for the (further) development of such national policies. These recommendations can be summarized as follows:

National policy vision on social inclusion

Key persons in all three regions believe that a broad and genuine acknowledgement and promotion on a national government level is required of the social and economic benefits of community support and social inclusion of persons with severe mental health problems, not only for those involved but for society as a whole. This acknowledgement should not be restricted to the health care department but should have cross-departmental and broad political support.

National framework of responsibilities, entitlements and services

A national framework should be developed, defining exact responsibilities of national, regional and local authorities and other relevant agencies (commissioning and funding agencies, including private health insurers) concerning community support services and social inclusion of persons with severe mental health problems. Especially end responsibility for coordination on a national, local and individual level should be addressed. Also entitlements of individuals with severe mental health problems should be made explicit, not only entitlements to services but also to housing and work.

Structural funding and inclusion incentivizing reimbursement systems

Directive implementation of community support and social inclusion policies primarily asks for solid funding and adequate financial incentives. Especially flexible, long-term and coherent, individual support in independent living, social contacts, education and employment should have 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

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. Criteria for integral funding should be made explicit in terms of clients' characteristics and needs and in terms of requirements of the budget-holder.

Innovation programs

As the further development of a comprehensive national social inclusion policy will need preparation, innovation programs and funds can have a crucial role in exploring, developing or expanding the desired service provision and in leading the way for mainstream health and social care systems.

Comprehensive policy plan

Policy measures concerning community support and social inclusion will be most coherent and efficient when integrated in a comprehensive, cross-departmental, national policy plan. Basic to that plan should be the awareness, as propagated by key persons involved in this study, that social inclusion of persons with severe mental health problems is not utopian. It can be organized.

1 Introduction

1.1 Objective

This report describes the results of an international comparison of the incentives and disincentives of national policies and funding systems on the development and implementation of comprehensive community support services for persons with severe mental health problems. These relationships were studied from the perspective of three mental health care regions in Denmark (the Aarhus region), England (the Nottingham region) and the Netherlands (the Alkmaar region) respectively. The regions that participated in the study are seen in their respective countries as good practices concerning community support for persons with severe mental health problems. Background and research approach of the study as well as the structure of this report, are discussed in this opening chapter.

1.2 The challenge of social inclusion

Deinstitutionalization of mental health care and the development of community care and community support for persons with long-term mental health problems have been policy issues in many Western European countries for some decades now. Recent studies of the Mental Health Economics European Network (MHEEN) suggest that it is “a widely held consensus today that delivering mental health services within the community is more appropriate than offering long-stay residence in institutions. It is widely recognized that community-based services have the potential to be more effective in achieving good quality of life for people with long-term needs for support. It is also recognized that community care is not necessarily more expensive than institutional care. Most importantly, care in community settings is generally preferred by service users” (Medeiros et al., 2008; see also McDaid and Thornicroft, 2005).

On the basis of these experiences a broad consensus has developed on the desirability of the deinstitutionalization and social inclusion processes. However, while separate countries do not differ so much in these objectives as such, they do differ in the range and the kinds of efforts they make to achieve these goals. These differences imply that in many countries there is still a lot that can be done. They also offer opportunities to learn from each other's experiences. More so because recent reviews show that there are still many barriers to overcome (Medeiros et al, 2008; McDaid et al 2008; Knapp et al 2009).

These barriers concern two aspects of the deinstitutionalization process:

- the development of *community care*: moving care from an institution to the patients' own home environment (home care)
- the development of *community support* – enabling patients to lead a satisfying social and working life (social inclusion).

Barriers to the replacement of institutional care by community care can be found in financial as well as cultural and human resource factors. In many European countries mental health care funding systems have long been and often still are predominantly attuned to institutional care. Financial incentives of these systems often still promote institutional care (McDaid et al, 2008; see also Van Hoof et al, 2009). Also perspectives, expectations and competencies of the mental health care workforce are believed to sometimes hinder the transfer from institutional to community care (Amaddeo et al, 2007; McDaid et al, 2005).

With regard to the development of *community support* and *social inclusion*, stigma of mental health problems is considered to be an important barrier. Stigma is found in society in general as well as in mental health care itself and specifically targets persons with severe mental health problems who have become unemployed and have at some time been admitted to inpatient mental health care facilities. Next to stigma the other main challenge concerning community support lies in the fact that the objective of social inclusion moves the support of persons with severe mental health problems into a complex 'multi-services' and 'multi-budget' world (McDaid and et al, 2007). A community support infrastructure is needed, consisting of mental health care workers and institutions as well as workers and organizations in other sectors, cooperatively and coherently paying attention to and trying to address clients' needs in the domains of housing, education, work and social life. Different from institutional care or even 'plain' community care (or 'outpatient mental health care') community support and social inclusion demand the involvement of several stakeholders, each participating from different cultural and financial contexts. One of the main challenges in the development of community support will therefore be the management of these organizational and intersectoral 'interfaces' (McDaid et al, 2007).

Economic and social circumstances

The transfer to community support systems currently takes place in the broader context of economic setbacks and longer term health care transformations in many Western European countries. These circumstances present additional risks but perhaps also some opportunities to the community support and social inclusion objectives. Economic circumstances lead to an increasing pressure to downsize public service expenditures. At the same time they present an opportunity to stress the economic importance of (investments in) social inclusion and participation of every individual member of society, including persons with chronic (mental) health problems. The liberalization of health care, that is currently taking place in many countries, entail risks of a focus of stakeholders

on short term financial benefits instead of long term cooperation and sustainable public health and participation gains. Provided that financial incentives point in right directions, it might also create opportunities for enhanced innovations. Likewise, the current trend of individualizing health care financing and budgeting might lead to a rigid entitlement orientation and underfunding of care for persons with severe problems. Alternatively it could also create new opportunities for demand driven care.

The growing number of sectors and financing structures involved in community support as a result of the deinstitutionalization process itself, also creates risks as well as opportunities. Opportunities lie in the fact that these sectors and their budgets are potential building bricks of a comprehensive and coherent support system. Risks lie in the fragmentation of budgets, silo-budgeting, fragmentation of decision-making, shoving off responsibilities and gaps in service funding and provision. Deinstitutionalization often also leads to the transfer of responsibilities and budgets from the (nationally controlled) health care to the (locally controlled) social care sector. This creates opportunities for engagement of the social sector organizations but it also creates risks of leakage of budgets to other groups which they serve or other services provided through the social sector.

To sum up, there are ample opportunities to grasp and there is a lot to be gained in the fields of community support and social inclusion of persons with severe mental health problems. But there are also many barriers to overcome and risks to avoid. For these reasons national guidance and coordination and national policies will be crucial to the outcomes of the deinstitutionalization processes and the realization of comprehensive and effective infrastructures for community support services for persons with severe mental health problems. These national policies are the focus of this report.

1.3 International study on the incentives for community support

Background

On an annual basis the Trimbos institute – the Dutch national research institute on mental health – produces *Trend reports* on the developments in mental health care in the Netherlands. The Trend reports are commissioned by the Ministry of Health Care. For the 2011 Trend report the Ministry of Health Care asked the Trimbos institute to address the subject of community support for persons with severe mental health problems. Community support being defined as those services and conditions that are necessary to enable people with severe mental health problems 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. It was agreed that the 2011 Trend Report should specifically focus on an exploration and comparison of the incentives and disincentives of national policy and funding systems for the development of community support for persons with severe mental health problems.

Many of the considerations in the previous paragraph are part of the motives for the Ministry's request. However two motives stand out. The first is that, due to a major reform in mental health care financing in the Netherlands, competitive health care insurers and to a lesser extent local governments have become important funding agencies and decision makers in mental health care in the Netherlands. The second motive is that, partly as a result of this reform and after a relatively long period of status quo, there has been a recent revival of deinstitutionalization objectives in Dutch mental health care. The consequences are not clear yet but are believed to need close monitoring. It is also believed that an international comparison of incentives and disincentives of national policy and funding systems on the development of community support, can help future policy making.

Study approach and participants

Given this request, the broad scope of the study versus the restrictions in terms of time and budget compelled us to make a few sharp choices concerning the study approach. First it was decided that the study should aim at an in depth view into the policies and systems of a restricted number of countries rather than a superficial overview of dozens. It was also decided that the countries to be studied should have maximum relevance for the Dutch situation in terms of a. maximum similarity in economic and cultural background and b. maximum divergence in national mental health care and community support policies and systems. It turned out that, next to the Netherlands, England and Denmark would be good candidates, being neighboring countries, but with significant differences in the respective histories and current status of their mental health care and community support services and policies in general and differences in inpatient capacity and the role of local and national authorities in particular.

It was anticipated that little representative and comparable quantitative information would be available (yet) in the three countries about the effectiveness of services and the social inclusion of the target population (let alone the causal relations with the respective national policies and systems). It was decided that quantitative data (for instance on number of psychiatric beds, capacity of other services, service use and costs) would be gathered to help understand the respective national systems, but not for benchmark objectives and only as far as readily available and documented (no extensive additional data collection would take place). As far as the incentives and disincentives of national policies and systems were concerned, perspectives and experiences of key persons operating in regional networks of care and support services for persons with severe mental health problems would be the main information source of the study.

Given this reliance on stakeholders' or key persons' experiences, it was finally decided that the study should concentrate on the experiences in relatively innovative regions or regions that are recognized in their respective countries as good examples of community support and of cooperation between mental health care and other sectors (housing, work). The argument for this is that those involved in innovative regions or

groundbreaking initiatives in general may be expected to generate the most and the most valuable information on the opportunities and barriers in the development of community support for persons with severe mental health problems. Also a regional approach would give the opportunity to take account of the level of cooperation and coordination in the respective regional community support networks.

It was decided that the incentives and disincentives of national policies and systems would be studied from the perspective of key persons of one innovative region per country. It was also agreed upon that, for comparability reasons, each of these three regions should consist of a middle-large town and its surrounding rural area. In addition, the presence of a potential regional research partner would be advantageous.

Consultation of national experts on these criteria ultimately led to the election of the Aarhus region in Denmark, the Nottingham region in England and the Alkmaar region in the Netherlands as the three innovative regions to address. Researchers and representatives of the Centre for Psychiatric Research of the Aarhus University Hospital, the Nottingham Institute of Mental Health and 'Geestelijke Gezondheidszorg Noord-Holland-Noord' (Alkmaar) were contacted and invited to participate in the study. In close collaboration between these research partners, the research questions and approach were further specified.

Research questions

The following four research questions were formulated regarding the participating countries/regions:

- a. What are the main characteristics of the national mental health care systems and of the national policies concerning the development of community support and social inclusion of persons with severe mental health problems?
- b. What are the main characteristics of the regional community support systems in terms of organizations involved, the roles and services of these organizations concerning the community support of persons with severe mental health problems and the capacity, funding and coordination of these services? What makes the regions 'innovative' in their respective national contexts?
- c. According to representatives (key persons) of the regional organizations involved, what are the main incentives and disincentives of the national policy and service systems for the development of community support for persons with long-term mental health problems in the region?
- d. According to representatives (key persons) of the regional organizations involved, what could be done on a national level to (further) stimulate, promote and facilitate the development of community support for persons with long-term mental health problems?

On the basis of the answers to the questions above, the study concludes with the following two general questions:

- e. What parallels and what differences are encountered between the countries/regions concerning national policies and systems, characteristics of regional community support systems and perspectives of regional key holders on incentives and disincentives for community support?
- f. To what general conclusions and eventual suggestions do these findings lead concerning national incentives and national policies for community support?

Research set-up

To generate the information and data concerning these research questions, a three-stage set-up was agreed upon, consisting of:

Stage 1. Context analysis (research questions a. and b.): orientation on the characteristics of national mental health care systems and policies and on the community support in the respective regions through:

- Interviews with national experts and document analysis on national policies and systems. With special focus on mental health care structure, inpatient and outpatient capacity, levels of control of national and local authorities, funding and ring-fencing of budgets, entitlements, general policy frameworks and specific national measurements to promote the development of community support.
- Interviews with regional research partners, documents analysis and a structured data collection (by regional research partners) on the basis of a short checklist on the characteristics of the regional community support systems. With special focus on inpatient and outpatient capacity, organizations and services in the fields of housing, social support, education and work, recovery orientation and coordination of services.

Stage 2. Inventory and analysis of the respective national incentives and disincentives and suggestions for national policy measures to stimulate and promote community support (research questions c. and d.):

- Individual interviews in all three regions with key persons in the local community support network. In particular key persons were invited from the fields of long-term mental health care, housing, participation (education and work), recovery and commissioning and coordination. Interviews entailed a short check on the results of the context analysis and further focused on the perspectives of key persons on the current quality and eventual shortcomings of the regional community support system, future plans and aspirations concerning community support in the region, incentives and disincentives of the respective national policy and funding systems and suggestions for national policy measures that might enhance the development of community support and social inclusion.

- A series of three closing group interviews in each of the three regions with the key persons that had been interviewed on an individual base. With special focus on remaining black spots concerning national policies and regional situations and the consensus concerning the prevailing incentives and disincentives and concerning the suggestions for future national policies.

Stage 3. General analysis of parallels and differences between the results in the respective countries/regions and the overall conclusions to be drawn from these (research questions e. and f.)

- Presentation and discussion of interim results and the preliminary end result with the members of the project group and with members of a small external advisory board (representing WHO Europe and the international research community on psychiatry and community support; see appendix).

Conducting the research

Research activities were carried out by members of the project team, consisting of the researchers of the four collaborating organizations. Research partners in the respective regions directed the search for national and regional data and documents, provided the basic data concerning the regional community support services, selected and approached the relevant regional key persons, co-arranged organizational and content preparations for the group interviews and co-analysed the interim and end results. Researchers of the Trimbos-instituut coordinated the project, conducted all of the interviews and composed the interim and concept end reports.

1.4 Structure of the report

The next three chapters of the report deal with the findings concerning the country and regions of Denmark/Aarhus, England/Nottingham and The Netherlands/Alkmaar respectively. In each chapter the following topics will be discussed:

- National mental health care system (services, organization and funding)
- National policy on mental health care and community support
- Characteristics and community support services of the region
- Regional key persons' perspectives on the incentives for community support

In the closing chapter a comparison will be made of national policies and systems and the regional key persons' experiences, perspectives and suggestions. This comparison is followed by a general analysis of national incentives and disincentives for community support and implications for future national policy measures.

2 Denmark - Aarhus

2.1 The Danish Mental health care system

The current mental health care system in Denmark can be described as the result of two important processes. The first is a gradual, long-term process of deinstitutionalization. The second is a radical health care reform in 2007, leading to a shift of a large part of responsibilities to the municipalities.

As deinstitutionalization is concerned, several figures show that the total number of psychiatric beds in Denmark has declined significantly in the past 15 to 20 years. Whereas, according to Priebe et al. (2008), Denmark counted 112 psychiatric beds per 100,000 inhabitants in 1990, this number was reduced to 76 in 2005 (or approximately 4,000 in total). The WHO, using somewhat different definitions, calculates a decline from 92 beds per 100,000 in 1991 to 60 in 2007 (approximately 3,200 in total). In both instances, the figures come down to a reduction of inpatient capacity of about one third. Also, in both instances the recent figures indicate a relatively low psychiatric inpatient capacity, compared to other Western European countries (although Denmark, as will be shown later, does seem to have a relatively large number of residential care and supported housing facilities).

The second important factor in the coming about of the current mental health care system in Denmark is a structural reform in 2007. From 1976 until 2007, the largest part of specialized mental health care was organized and mainly financed through a single county-based structure. As a result of a comprehensive administrative reform in 2007, a double transfer took place. A large part of mental health care was transferred to the municipalities. Specifically social psychiatric and housing facilities became the explicit responsibilities of the municipalities. The remaining part i.e. the core 'treatment' business of secondary mental health care (inpatient and outpatient services) became the responsibilities of five regional health care authorities, especially of the hospitals run by these regional authorities¹. The shift was important both in quantitative as in qualitative terms. In quantitative terms, the shift led to a very significant share of the municipalities in total mental health care expenditures (approximately one third to a half). In qualitative terms not only did municipalities become a dominant partner in mental health care, also the originally fairly integrated specialized mental health care sector itself was split into two main domains, at least as control and finance were concerned.

1 The structural reform, implemented in 2007, was in fact aimed at the Danish administrative system as a whole. The fourteen relatively small counties were replaced by five large administrative regions and the number of municipalities was brought down from a few hundred to ninety-eight. Resulting changes for mental health care were part of consequences of the reform for health care as such. More specifically the reform resulted in the five new regional health care authorities owning and running hospital care and financing general practitioners, specialists, physiotherapists, dentists and pharmacists. The ninety-eight municipalities became responsible for nursing homes, home nurses, home care and services for drug or alcohol addicts.

As a result, current mental health care services in Denmark can be described along two lines: regionally versus locally managed services. A description of each of these two sectors (and their interconnections) is presented below. In addition the role of primary care providers in mental care will be described.

Regionally managed mental health care

Each of the five regional health care authorities in Denmark holds responsibility for the organization and provision of health care in that region. As part of that, the regional health authority also holds responsibility for the treatment ('curative') part of mental health care. This means: psychiatric inpatient facilities and specialized outpatient mental health care. Inpatient care is provided by psychiatric hospitals. Outpatient care is provided by outpatient clinics that are either located at the hospital site or in Community Mental Health Centers. Through the outpatient clinics the regions also provide social and community psychiatric services, but only as far as treatment is concerned. This means that professionals of regional mental health care do pay home visits, but that the focus is on diagnosis and treatment, particularly of a psycho-pharmacological nature, and on establishing a coherent treatment plan, in cooperation with the psychiatric hospital and the GP. In practice mental health home care is especially issued by the region in case of deterioration of the mental state of the client and to assess symptoms, function deficits and unmet needs. Also in the treatment plans that are commonly used in the regional mental health care system, biological and psychological components and the current psychiatric problems are the main issues.

In terms of professions, regional mental health is mainly staffed by psychiatric nurses, psychiatric nurse helpers, physicians and medical or therapeutic specialists. In terms of client characteristics regional mental health is mainly oriented at clients who require (multidisciplinary) treatment and care. The vast majority of referrals comes from the GP. (It is also the GP who performs compulsory admission according to the Mental Health Act.)

Locally managed mental health care

The *municipalities* in Denmark are responsible for general social services. In 2007 explicit responsibilities were added regarding housing facilities for persons with severe mental health problems, day and night care facilities, social psychiatric services (with the exception of the treatment aspects of social psychiatry) and facilities for day activities, social contacts and participation (including school, work and leisure)². The municipalities mainly provide these services themselves, although a part may be contracted from the regions, other municipalities or private organizations. Clients of the municipal social mental health care facilities are usually suffering from severe and persistent mental health and social problems and sometimes also from alcohol or drug misuse. Most of the clients are referred to municipal facilities by regional psychiatry.

2 Some municipalities (among which Aarhus) had already developed some basic support services for persons with mental health problems before 2007.

Municipal housing facilities for persons with severe mental health problems include several types of accommodations, including nursing homes, sheltered accommodations and half way houses. Some of these accommodations are staffed day and night, others at daytime and evenings only. It has already been mentioned that Denmark has a relatively low number of conventional psychiatric beds but a relatively high number of residential care and supported housing facilities, compared to other Western European countries. Priebe et al. (2008) estimated the total number of places for residential care and supervised and supported housing for persons with mental health problems in Denmark at 87 per 100,000 inhabitants in 2006 (which comes down to a total of approximately 4,500 places)³. This was the highest number for all nine Western European countries involved in the study. In addition, the study showed that this number has been fairly stable over the past 15 to 20 years (in 1990 the total number of places in residential care and supported housing facilities already was 82 per 100,000 inhabitants). This persistently high number is also in contrast with many other countries, where supported housing facilities were virtually non-existent in 1990 and only began to emerge and expand since then.

Next to housing, social psychiatric home care plays an important role in the municipal services for persons with (severe) mental health problems. Central to this facility (and to the municipal mental health care system as a whole) is the Mental Health Social Worker (MHSW). For most clients with severe long term mental health problems, the MHSW is the primary contact person for the local mental health care and support system. In practice the MHSW pays regular home visits to the client. Main objectives are to assist the client with everyday life, to establish a primary alliance and to offer social support and social training. Activities may entail everyday help in and about the house, co-attend with the GP or the social security office, motivate the client to attend social psychiatric or community facilities or to engage in work or day activities and offer explicit or implicit social skills training. Goals, targets and support activities are documented in an action plan, set up in dialogue with the client. It is estimated that one third of the municipalities' clients with severe mental health problems also receive general home care or home nursing services through general municipal assistance facilities.

A third section of the municipal mental health care system consists of facilities for day activities, social networking, education, vocational rehabilitation and (sheltered) work. Usually, this section consists of a diverse, locally colored range of projects.

Community Mental Health Centers

Regional and municipal mental health care are two separate systems. This does not mean that they perform separately, however. In fact, partly because of historical reasons, large parts of both systems are represented in local community mental health centers.

3 Total inpatient and residential facilities in Denmark would add up to approximately 8,000 places or 145 per 100,000 inhabitants.

An extrapolation of 2009 Aarhus figures (see paragraph 2.3) indicates that at that time an estimated one third of CMHC's staff were employees of the region and two thirds were employees of the municipalities⁴. There is also an overlap of client populations of the regional and municipal system. Or to put it otherwise, a considerable part of clients with severe or long term mental health problems get support and treatment from municipal as well as regional facilities. As a matter of fact, joint planning and mental health care agreements between the regions and the municipalities are prerequisites for funding (see paragraph 2.2).

Primary care

Next to the specialized regional and municipal mental health care systems, primary mental health care by GP's, private practicing psychiatrists and psychologists play a substantial role in Danish mental health care. In terms of client characteristics, the GP's largely concentrate on persons with anxiety, depression and personality or functional disorders and on psychiatric symptoms associated with somatic diseases. Furthermore, the GP takes care of the follow-up of many clients with more chronic mental health problems. Also GP's play a pivotal role in admissions to other primary mental health care or regional mental health care providers (also in the case of hospitalization and compulsory treatment).

The private practicing psychiatrists predominantly concentrate on pharmacological treatment and short-term psychotherapy, while the private practicing psychologists particularly perform in acute or more protracted crisis situations, in couples or family therapy and sometimes in assessments tasks.

Based on an extrapolation of the Aarhus point prevalence figures (paragraph 2.3), on every 100 clients of the municipalities, there are an estimated 150 clients of the regions, 275 clients of private practicing psychiatrists and (predominantly) psychologists and 400 mental health clients who receive treatment from GP's (figures with overlapping client categories). In terms of public expenditures, the estimated shares of municipal mental health care, regional mental health care and primary mental health care (excluding GP's) are 40 %, 55 % and 5 % respectively.

Finance, funding and expenditures

Following the principle that there should be universal, free and equal access for all citizens, the Danish healthcare system is for the largest part a public healthcare system. Entitlements are specified in a National Health Insurance and the health care system itself is financed through general taxes. Until 2007 the health care budget was generated by a mixture of taxes. In 2007 taxation for health care was concentrated in a centrally-collected tax set at 8% of taxable income and earmarked for health. The central government allocates this revenue to five regions (80%) and 98 municipalities (20%) using a risk-adjusted capitation formula and some activity-based payment.

4 Recent developments in Aarhus result in fairly different figures (see paragraph 2.3).

As mental health care is concerned, specifically regional mental health care is predominantly dependent on state funding (the region itself does not impose taxes). The size of the funds is based on production estimates of Disease Related Groups (DRG) services and is negotiated each year. Municipal mental health care is also partly dependent on state funding, but municipalities also impose taxes themselves. Overall municipal and regional budgets are regulated by the state. However, both the regions and the municipalities are at relatively great liberty to decide what parts of the budgets are spent on mental health care and specific mental health care services (no ring-fencing of mental health care budgets⁵). National guidelines do prescribe in general terms what services should be delivered, but they do not prescribe their size or client capacity. This means that the latter are for a great part dependent on the results of periodic negotiations on the regional and municipal level.

As primary mental health care is concerned, there is open and free access to the GP (all GP's have an agreement with the National Health Insurance). This is not fully the case for private practicing psychiatrists and psychologists. Approximately 75 percent of private practicing psychiatrists and only an estimated 25 % of private practicing psychologists have an agreement with the National Health Insurance⁶.

While client capacity and budgets of specific regional or local services are not nationally prescribed, the individual client's rights to treatment and support are. Some national measures have been implemented to promote that these rights can at all times be effectuated. One example is the measure by which private practicing psychologists or psychiatrists will be publicly funded (also if a practitioner has no agreement with the national health insurance), if treatment by the publicly financed mental health care system cannot be provided within a given period ('treatment guarantee'). Another example is the measure that the municipalities must pay for prolonged psychiatric hospital stay for clients whose treatment is complete and who might be discharged if adequate service was available for these clients. Total income of the regional mental health care system (the provider of psychiatric hospital care) from the municipalities change from year to year and ranges from 5 % to 15 % of the region's psychiatry budget.

According to the WHO, total mental health care expenditures in Denmark are approximately 7.5 % of the total health care budget (WHO, 2008). This would mean that the total mental health care expenditures in 2008 amounts to an estimated 1,250 million euro, or approximately 230 euro per capita.

5 Only in the two years after the structural reform of 2007, municipalities were obliged to preserve the budgets for social psychiatry at the pre-reform level.

6 Psychiatrists and psychologists in the primary care sector without agreements are paid by the clients themselves or through additional private health insurances.

2.2 Danish national policy on mental health care and community support

Much of Danish policy on services for persons with (severe) mental health problems can be inferred from the above. A longstanding policy goal of deinstitutionalization and more recent measures directed at decentralization can be identified as main policy issues.

In the past few years some new national mental health care policy documents have been published by the Danish government. Important ones are the *National strategy for psychiatry* ('National strategi for psykiatri'), the *Action plan for psychiatry* ('Handlingssplan for psykiatri'), and *Acute action for Psychiatry* ('Den akutte indsats på psykiatriområdet') (Sundhedsstyrelsen, 2009a; Sundhedsstyrelsen, 2009b; Regeringen, 2009). The current national policy goals, outlined in these documents, partly seem to be a continuation of previous objectives, but with some new accents. The policy goals can be summarized as improving accessibility, enhancing quality of professional care and promoting and facilitating participation.

The availability of sufficient diagnostic, treatment and rehabilitation services has become an issue since there are indications that the growth of the total national mental health care budget has in recent years been lower than the growth of the overall health care expenditures. Access to mental health care and rehabilitation services is believed to be under pressure. The subject of quality of care is predominantly promoted from the perspective of professional norms and standards and investments in research (specifically of clinical activities). As the titles of policy documents suggest, the professional psychiatric perspective seems to have a relatively strong voice in the quality paragraphs of the national mental health care policy. Within this context, emphasis is also placed on dissemination and implementation of knowledge about mental health promotion and prevention, reduction of unnecessary mortality and morbidity and reduction of the disabling impact of mental disorders.

National perspective on social inclusion

Next to access and professional quality, the participation of persons with mental health problems is a predominant issue in the national policy papers. Policy documents state that society has responsibilities towards people with mental health problems and that opportunities should be increased for psychiatric clients to recover. Persons with mental health problems should have ample opportunities to participate. Therefore, attitudes towards people with mental health problems should change, while autonomy and self-determination should become leading principles in support services. In addition, to ensure that individuals with mental health problems receive adequate overall support in their mental, social and school or work place functioning, cooperation and coordination of support services is necessary, not only within mental health care but also across the social and care sectors. To this end social and care sectors are invited to work together

and to create a well-planned organization of a broad spectrum of support services. Emphasis is placed on coordination, continuity and commitment and on transparent agreements on cooperation and shared responsibilities between actors.

Policy measures

Several policy measures have been taken in recent and earlier years that should help implement these social inclusion and participation policies. These measures range from individual or group entitlements to innovation funds and the promotion of cooperation between care providers on an individual and a local level. Specific entitlements have been introduced in the fields of work, education as well as housing. As work is concerned, there are special arrangements for jobs with a “sheltered” or “flexible” status (for employees with restricted working capacity). Also, according to a relatively new national law, companies are obliged to employ a certain number of persons with mental health problems in their organizations. Persons with mental health problems can also profit from legally guaranteed special education programs. And as clients of municipal social care facilities, persons with mental health (or social) problems have a first right to a quarter of all apartments offered in the public housing service.⁷

Coordination of services across social and mental health care is an important element of the Mental Health Act. According to the Mental Health Act, coordination is obligatory in individual service planning for persons with severe mental health problems. More specifically, an integrated social and mental health care coordination plan is mandatory for persons with severe mental health problems. In this coordination plan, the roles of all professionals involved are formalized (including professionals from the municipal and the regional system)⁸.

Coordination of services at an aggregated level is promoted through the mandatory common Health Agreement. The agreements are set up every four years. In the agreements the regions and the municipalities plan, negotiate and attune their respective facilities and services. The agreement has to be approved of by the national authorities and is linked to the assignment of regional and local budgets. A related measure, that has already been mentioned in the previous paragraph, concerns the municipalities' obligation to pay for a prolonged psychiatric hospital stay if adequate social psychiatric help or residential care would be good alternatives but are unavailable. This measure is intended to motivate municipalities to cooperate with the regions in preventing unnecessary hospitalization and to provide adequate, sufficient and accessible social support services.

In addition to the structural instruments mentioned above, there are some special (temporary) national projects. One important example of these is an extensive 4-year

7 In some locations - as in Aarhus - there are also cooperation agreements between housing associations and CMH centres concerning support to tenants with severe mental health problems.

8 The coordination plans do have a time limit of 6 or 12 months. In practice they are often set up at dismissal from the psychiatric hospital.

project aimed at combating homelessness in the big cities. Eight cities temporarily receive extra funds to prevent homelessness and to implement interventions that have been identified as evidence based by the national Social Research Institute. The program is financed through a special national social and health care innovation fund (called SATS). Another example is the national campaign that is being launched to combat stigma.

As a preliminary conclusion we might state that community support and social inclusion of persons with severe and long term mental health problems are central issues in the Danish national policy. In paragraph 2.4 the judgments of the consulted experts and key persons on the effectiveness of this policy and the several policy instruments will be discussed. Before we get to that, we present an overview of mental health care and community support services in the region of Aarhus.

2.3 Characteristics and community support facilities of the Aarhus region

Aarhus is a municipality in the Region Central Jutland (in Danish: Region Midt). Part of the municipality is the city Aarhus, the second largest city of Denmark. In our study, when we speak of Aarhus, we are referring to the Aarhus municipality.

The municipality of Aarhus has approximately 307,000 inhabitants of whom about 240,000 live in the city. The municipality covers about 468 square kilometers (655 inhabitants per km²). Compared to the overall Danish population, Aarhus has a relatively high proportion of persons in the lower wage categories but also a relatively high proportion of persons with high education and in high level functions. This combination is probably due to the fact that Aarhus is a university city. Also Aarhus has as relatively low number of elderly and a relatively high proportion of inhabitants in the age category of 19-64 years.⁹

Mental health care in Aarhus

Mental health care systems are constantly in motion and this is specifically the case for mental health care in Aarhus (see also Aagaard et al, 2008). It is good to be alert to the fact that the description in this paragraph has the features of a snapshot of the 2009-2010 situation. Wherever possible, we will point at relevant developments since.

In general and in accordance with the Danish mental health care system, mental health care in Aarhus is organized along the lines of regionally managed secondary mental health care, municipal mental health care and primary mental health care. In this paragraph we will refer to the first of these three segments as *secondary mental health care*.

9 Sizes of the age groups are: 65,000 (21 %) <19 year, 202,000 (66 %) 19-65 years and 40,000 (13 %) > 65 years.

Secondary mental health care in Aarhus is provided by the Aarhus University Hospital (AUH). The hospital has a slightly larger catchment area than Aarhus Municipality¹⁰. The Aarhus University Hospital provides psychiatric inpatient facilities at the hospital site and outpatient facilities at the hospital site and, until recently, in a number of Community Mental Health Centers (CMHC's). Outpatient facilities at the hospital site are organized in specialized clinics for schizophrenia, anxiety, personality disorder, bipolar disorder, suicide prevention and neuropsychiatry. Community Mental Health Centers generally provide secondary outpatient mental health care and are, up until now, managed and staffed in cooperation with the municipal mental health care system.

It is important to note that the involvement of the Aarhus University Hospital in the CMHC's is currently being diminished and that regional psychiatry's outpatient care is gradually being withdrawn to the hospital site. Parallel to that, plans of the Hospital are in progress to create their own psychiatric nurse mobile team, which will temporarily support clients in the weeks and months after dismissal from the hospital. (Reasons and consequences of these recent developments will be discussed later).

In 2009 the psychiatric inpatient capacity for adult (>18 years) inhabitants of Aarhus amounted to an average of 162 occupied beds (point prevalence; including 14 beds for age category 65+). That comes down to 53 occupied adult beds per 100,000 inhabitants in Aarhus municipality, which is a relatively low capacity to Danish standards. The total number of admissions of adults was 3,446 (including 262 admission for age category 65 +). The average duration of an admission was approximately 17 days.

In terms of personnel, the Aarhus University Hospital has a capacity of 727 full-time equivalents (196 per inhabitant of the municipality; 2009 figures). Approximately 200 are employed at the forensic and geronto psychiatric services, the other 500 at the regular psychiatric hospital wards, CMHC's and specialized clinics. Slightly more than half of these 500 are related to the hospitals' inpatient services. In total, an estimated 78 % of staff is employed for 19-64 year old residents of Aarhus Municipality.

10 For some specific patient groups the catchment areas are larger than the 'regular' area. Specifically for geronto psychiatric patients the catchment area is somewhat larger, while for forensic mental health patients the catchment area is much larger.

Table 2.1 Mental health care staffing in Aarhus University Hospital (full time equivalents)

	N	%
Psychiatric nurses	172	24
Nurse helpers	216	29
Physicians	83	11
Psychologists	63	9
Physio-, occupational therapist and social workers	87	12
Other academic	7	1
Medical secretaries	57	8
Technicians, kitchen and cleaning staff	24	3
Office staff	13	2
Not-classifiable	7	1
Total	727	100

Table 2.1 shows that more than half of the secondary mental health care staff of Aarhus University Hospital consists of psychiatric nurses and nurse helpers, other staff mainly consisting of physicians, psychologists and therapeutic specialists.

In addition to the secondary mental health care services of Aarhus University Hospital, the Aarhus Municipality provides services especially aimed at persons with severe mental health problems. These services consist of non-treatment residential care, non-treatment social psychiatric care and participation services.

Municipal residential care is provided through 27 residential institutions, of which 6 are staffed at nights. These residential institutions range from basic bed and bath facilities to care homes, sheltered living arrangements, 'half way houses' and clustered individual apartments with support services at close distance. Not all of these residential institutions are specifically focusing on persons with mental health problems as such, although many residents belong to this category. Some institutions are specifically aiming at homeless people (Aarhus municipality runs a series of projects financed by the temporary national SATS-fund to combat homelessness- see paragraph 2.2). Others focus on specific client groups such as adolescents or persons with double diagnoses. At a given point in time the institutions in Aarhus provide residential care to 307 persons (100 per 100,000 inhabitants of the Aarhus Municipality). It is the municipality's policy to reduce this number by promoting outflow, by setting time limits to the individuals rights to residential care and by adopting the 'Housing first' principle.

General social psychiatric care is mainly provided by Mental Health Social Workers, stationed at the Community Mental Health Centers. In Aarhus, as in the rest of Denmark, the MHSW often is the primary contact for persons with severe mental health problems. Activities are mainly orientated at home visits, assistance in everyday life and social

support and social training. Acute outpatient care and crisis intervention at nights and in weekends is provided by the Acute and Assertive Team (run by the municipality but co-financed by the region). Team members are MHSWs with 'regular' jobs next to their periodic shifts in the Acute team (which is said to be unique in Denmark). Outreach services are mostly connected to one of the residential institutions or homelessness projects mentioned above.

Municipal facilities in the field of social participation are provided through general day activity and meeting centers. But Aarhus also counts a range of specific projects in the domains of work, education and participation. We will elaborate on these community support services below.

The total staff of municipal mental health care in 2009 was 483 full-time equivalents (157 fte per 100,000 inhabitants). Table 2.2 shows that municipal staff consists almost entirely of Mental Health Social Workers. About 45 % of staff is employed at the residential facilities, 35 % at social psychiatric services (home care) and 20 % at the day activity and meeting centers.

Table 2.2 Mental health care staffing in Aarhus Municipal mental health care (full time equivalents)

	N	%
Mental Health Social Workers	418	88
Psychiatric Nurses	11	2
Administrative functions	32	6
Others	22	4
Total	483	100

In addition to the University Hospital and the municipality services, primary mental health care in Aarhus is provided by 203 fte GP's (66 per 100,000), 57 fte private practicing psychologists (18 per 100,000) and 10 fte private practicing psychiatrists (3 per 100,000).

The estimated total expenditures of secondary and municipal mental health care services for adults (19-64 year) in Aarhus in 2009 add up to 71 million euro (351 euro per capita). Approximately 58 % (43 million euro) of these expenditures are in the regional system and 38 % (29 million euro) in municipal care. The estimated total expenditures of primary mental health care (excluding GP's) for adults (19-64 year) in Aarhus in 2009 are 5 million euro (23 euro per capita).

Mental health care consumers in Aarhus

Table 2.3 shows the number of adult (19-64 years) Aarhus residents using some kind of mental health care services at a given date in 2009. Important to note is that a pronounced overlap exists in client populations of separate services. Approximately

30 % of 2100 CMHC patients have contact with the municipality's social psychiatry and approximately 25 % have contact with the municipality's day activity and meeting centers (and all of them are attached to GP's). As a matter of fact the *municipal* services receive most of their clients through *regional* psychiatry. Annual admission rates to mental health care through the regional system are estimated at 3,500. Estimates of the total number of clients (point prevalence) in secondary and municipal mental health care also come down to 3,500 (or 1,750 per 100,000 inhabitants).

Table 2.3 Estimated point prevalence of adult (19-64 years) Aarhus residents using mental health care services in 2009

	N	Per 100.000
Secondary mental health care (under the Regional Health Authority)		
Psychiatric hospital	150	75
Specialist outpatient clinics	500	250
Community Mental Health Centers	2,100	1,150
Municipal mental health care (under the Municipal Authority)		
Residential services	250	125
Social psychiatric and participation services	1,250	625
Primary mental health care (under the National Health Insurance)		
Private practicing psychiatrists	1,000	500
Private practicing psychologists	3,000	1,000
GP's	6,000	3,000

About one third of the clients of the regional system can be defined as long term regional mental health care consumers (more than 2 years of continuous contact with regional psychiatry). This group accounts for slightly less than 1 % of the adult residents of Aarhus municipality. Among the clients of the municipal system, more than half can be defined as long term (> 2 years continuous contact) municipal mental health care consumers. It is assumed that especially in the populations of long term mental health care consumers, there is a pronounced overlap between the client populations of the region and the municipality.

Community support services in Aarhus

The community of Aarhus has a tradition and generally is considered a precursor in the field of social service and community support for vulnerable people. Also cooperation in this field between the municipality and the mental health care system dates from long before the structural reform of 2007. As a result, a range of community support services has developed throughout the years. These services concern the housing and home care facilities, as described above, but also facilities in the fields of social networking,

day activities, work and education. Many of these activities are initiated by the mental health care system and by the municipality. But also user organizations and other Aarhus municipal departments in the fields of social services and employment are involved.

As the municipal mental health care system is concerned, recreational, educational and vocational services are offered in approximately 10 locations by a staff of about 150. Activity and meeting centers play an important role in this service system. The centers are visited on a weekly basis by approximately 400 clients of whom 200 are long term mental health care clients (> 2 years in social psychiatry). In addition, a range of specific projects and services has been developed. Examples in the field of networking are the *Network family* project, where the client is assigned to a family with regular arrangements, and the *Flexbo* project, which is a special offer to clients with severe problems in social relations. A specific project, aimed at clarification of preferences and opportunities of clients in the field of work and education, is the *Network group*. Specific sheltered work places in Aarhus are the Fountain House, offering work and education to approximately 25 long term mental health care clients, and the Forest Edge, offering place to approximately 30 long term clients.

An important service in the field of education is the CSV (Center for Special Education), offering group and individual support in education for adults with 'mental vulnerability'. The Education Center is initiated in accordance with the national compensatory special education law (see paragraph 2.2). Services are tailored to the individual needs of the student. The Center has a staff of 17 and an annual number of 400 students in 2009. Approximately half of these students (200) are persons who have been in contact with mental health care for more than two years.

A crucial municipal organization in the field of vocational services is the ARK, a unit of labor market consultants, working across the Department of Social Services and the Department of Employment in Aarhus Municipality. The unit consists of a variety of different projects seeking to help people, who are mentally ill and/or socially excluded, back into the ordinary work force. ARK has a large network of companies with which they collaborate. The projects are based on the method of "Individual Placement and Support". After a thorough analysis of the client's needs and wishes, the consultants try to find the right company for the client. When employed, the client is coached at the workplace continuously.

In addition to the mental health care and municipal services mentioned above, there are various user-run activity and work projects in Aarhus. An important, independent user-run organization is Gallo, financed through several municipal and national funds and offering supported and voluntary jobs to approximately 150 persons. Jobs are for instance in public education and catering (several canteens and a client café in the center of town that is also open to the general public). A national mental health care consumer and family organization, called Sind, is also active in Aarhus and runs several day activity,

education and work projects, including a private company that creates jobs for persons with mental health problems.

Of special importance to the recent and current developments in community support in Aarhus (next to the services themselves), is the recovery program that has been launched in the municipal mental health care system shortly after the structural reform of 2007 (when social psychiatric services were transferred from the county to the municipality). The program contained an extensive obligatory course in recovery principles and practices to all municipal mental health care workers (from outreach workers to ARK consultants), a dissemination program of best practices and an improvement program. As recovery is about perspectives, experiences and empowerment of persons with mental health problems themselves, consumer organizations were involved in several stages of the project. They participated in the steering community and in the project organization and education program. Professional managers and counselors did take the lead however in the initiation, design and coordination of the project and in education of mental health care employees. Recent evaluation of the recovery program led to the conclusion that many positive results have been realized (see also paragraph 2.4). At the same time it was concluded that in the next stage of the program a shift should be made from the initial managerial and professional top-down approach to a bottom-up approach, sharing experiences of workers and especially consumers in daily life and daily practice. These insights have been incorporated in the strategy for the next few years.

Cooperation and coordination of services

Where the organization and coordination of the various community support services for persons with long term mental health care are concerned, there is no specific mandated coordinating agency. The local organization of community support can be described as a relatively open network, a network that has developed from a long and strong tradition of local cooperation. In the past the mental health care system has developed close relations with other municipal sectors, the housing sector and the police. Cooperation has also developed between mental health care and user organizations, for instance concerning the exchange of information and information campaigns for the general public. One of the results is an annual "Mental Health Day" in the town hall, organized and run by users and staff of the various centers, and accessible to the general public. Within the mental health care system itself, some joint services of the regional and municipal mental health care systems have been set up (for instance the acute crisis team).

In addition, a few arrangements and instruments support local networking and cooperation in community support services. One of these is a monthly meeting of representatives of a core group of partners, exchanging information and seeking for joint solutions for the problems that are encountered. Once in every three months this meeting also takes place on a higher executive level, between managing directors. Next to that, the obligatory Health Agreement between the region and the municipality (see paragraph 2.2) helps to exchange plans and attune services. Since 2007, the Health Agreement has to be drawn up

every four years. While the first agreement in Aarhus had the character of a document of good intentions, the second one is more specific on certain joint goals and implementation of services. A coordination and cooperation tool on the individual level is the obligatory coordination plan for persons with severe mental health problems. This coordination plan is also extensively used in daily Aarhus mental health care and community support practice.

Latest developments

At the start of the paragraph we noticed that the mental health care and community support system in Aarhus (as elsewhere) is constantly in change. A crucial element in the latest developments is the Masterplan of the region (owner of Aarhus University Hospital), expressing the intention to re-organize services in diagnostic categories, further concentrate outpatient service on the Hospital site and withdraw from the Community Mental Health Centers (Aarhus University Hospital, 2010). The Masterplan is believed to have serious consequences for mental health care and community support in Aarhus, as will be shown in the next paragraph.

2.4 Regional key persons' perspectives on incentives for community support

Perspectives on the achievements, eventual shortcomings and future challenges of the local community support system in Aarhus were further examined and discussed in a series of individual and group interviews with approximately twenty key persons in the local community support network (see appendix). Interviewees represented the full range of relevant (professional and client) organizations and services in the domains of mental health home care, housing, participation (education and work), recovery, coordination and planning. Next to the local situation, the interviews specifically focused on the incentives and disincentives of the national policy and mental health care system regarding the development of community support and social inclusion.

Community support achievements in Aarhus

In general, key persons believe that conditions for social inclusion of persons with severe mental health problems in Aarhus are relatively good, especially compared to other regions in Denmark. Interviewees refer to the relatively strong social psychiatric tradition in Aarhus, the tradition in the field of social services for vulnerable people in general and the history of cooperation between mental health care, the municipality and user and relative organizations. Key persons also refer to the many services that have been developed in the domains of home care, housing, work and education. The Homelessness program also has its effects: the latest figures show that the number of homeless persons in Aarhus is decreasing. Key persons suggest that relevant organizations in Aarhus in general do have a sense of mutual interest in the development of adequate community support services for persons with severe mental health problems. Also relations between professional organizations and client and family organizations and

consumer run projects are also believed to be intensive and constructive. It is suggested that the transfer of social psychiatric services to the municipality has led to increased contacts between mental health care and other municipal departments. Within mental health care itself, cooperation between the municipal and regional system has so far profited from the joint housing in the community mental health centers.

Many key persons also get the impression that the recovery program has had a profound impact on the perspectives of professionals regarding persons with severe mental health problems and their potential to lead a meaningful and productive life. Perspectives on chronicity have become less rigid and orientation has moved towards opportunities for social participation, empowerment and recovery. The recovery program was evaluated on a client level. Research results suggest that, among others, clients gained self-confidence and got more social contacts during the program. Some interviewees suggest that doctors are now also aware of the importance of, for instance, the financial and housing situation of the client, for the treatment success. According to these interviewees, many professionals have in general (and often after initial skepticism) become enthusiastic about the recovery approach. Representatives of consumer organizations confirm that it has also become common to involve clients and client organizations in the planning and decision making on all levels. As noticed in the previous paragraph, a strategy for the continuation of the recovery program for the 2011-2013 period has been made and is currently being implemented.

No figures are available on the level of social inclusion and the quality of life of persons with severe mental health problems in Aarhus as compared to other regions in Denmark or abroad. In this sense, no definitive conclusion can be drawn on the effectiveness of the current local community support system. General opinion among key persons, however, is that Aarhus at least has a relatively solid basis from which to proceed. The challenge is in making optimal use of these favorable circumstances.

Positive community support incentives from the national policy and system level

According to interviewees the Danish national mental health care system and policy contains several features that are experienced as supportive to the objective of community care and social inclusion of persons with severe mental health problems.

Most appreciated are the specific group and individual entitlements that have been introduced in the domains of work, education and housing. In general, national authorities are valued for their efforts in creating education and employment opportunities for all. The experience of many key persons is that, as a result, chances for persons with severe mental health problems to regular or supported employment have risen in the past years. Also the first right of persons with social or mental vulnerability to 25 % of apartments in the public housing sector, has helped to arrange adequate living conditions for the greatest part of this population.

National regulations to promote cooperation on a local and individual level are also believed to be effective. According to many interviewees the obligatory Health agreement stimulates and facilitates the communication between the regional and the municipal services. It offers a framework for the communication between the wards and social psychiatry. It also offers a platform to discuss problems and negotiate about solutions. In general, the Health agreement is perceived as an effective encouragement for the establishment of a local consultation structure. In the same manner the nationally prescribed coordination plan for individuals with severe mental health problems is perceived by key persons as an effective instrument. It forces all professionals involved to attune tasks and responsibilities. It creates clarity to everyone involved and especially to clients themselves.

Specific national programs like the Sats program to reduce homelessness and the anti-stigma-campaign can also count on positive reactions of key persons. The homelessness program is, although temporary, perceived to have effect already, at least in the short run. The national anti-stigma campaign is still in the designing stage as this report is being written, but is also believed to have great potential.

There is one crucial feature of the Danish mental health care system however, that receives much more ambiguous judgments from the key persons in Aarhus. That feature is the dual system of a medically oriented regional psychiatry on the one hand and municipal social psychiatry and community support services on the other. Advocates of this system suggest that the transfer in 2007 of social psychiatry to the municipalities helped mental health care to break down walls around itself and specifically helped break down barriers to other municipal social services. Others, as we will see next, believe that the costs in terms of coherence and continuity of care are high and perhaps too high.

Barriers and future challenges in community support in Aarhus

The interview results suggest that Aarhus has a relatively solid basis from which to proceed in the development of a community support system for persons with severe mental health problems. However, a large part of the interviewees (representatives of both the regional and the municipal system) believe that the division of mental health care into two separate systems is not helping this pursuit but is in fact developing into a major barrier. Comprehensiveness, coherence and continuity are considered to be crucial to community care and community support for persons with severe mental health problems. These objectives are frustrated by the fact that even core ingredients of this care and support system are divided across two separate organizations, with separate funding systems and separate views. 'It's a divided world' as one of the interviewees puts it.

It is suggested that the division demands large investments in mutual consultation and meetings on all levels (individual and organizational). Mutual consultation is needed on financial, organizational as well as content matters, and both to attune current services as well as to guarantee continuity of services in time (for instance in terms of the

transfer of clients from social psychiatry to inpatient care and vice versa). As stated above, the health agreement and regular meeting of representatives of regional and municipal mental health care (and other organizations) are considered to be helpful. But key persons also mention that it is sometimes hard to reach a joint vision and a mutual engagement in concrete actions. In practice the meetings and the health agreement also function as negotiating platforms for organizations that each have their own interests. The same drawback is mentioned with respect to the obligatory individual coordination plan for persons with severe mental health problems. (Some interviewees suggest that implementation of the coordination plan as such is also still far from complete.)

In general and notwithstanding the solid baseline situation, a large part of the interviewees in Aarhus miss a shared leadership and a common vision. More so, it is a widely shared opinion that the recent Masterplan of the region (the authority controlling the regional part of the mental health care system in Aarhus) will further widen the gap between the two systems. As noticed in the previous paragraph, the region's Masterplan expresses the intention to re-organize services into diagnostic categories and strongly invest in specialization of staff in specific biomedical and cognitive therapeutic treatments of specific mental disorders. The Masterplan also states that regional psychiatry will concentrate outpatient service on the Hospital site and withdraw from the Community Mental Health Centers (thus far run jointly with the municipality and municipal mental health care workers). In general, long-term outpatient care will be left for a much greater part to the GP and the municipal system. The regional systems outreaching services will also diminish.

Many interviewees believe that the Masterplan is an indication that the biomedical oriented regional mental health care system and the psychosocial oriented municipal mental health care system are drifting apart. Some believe that this tendency is inherent to the dual mental health care system as such. It is pointed out that, for instance, the recovery education and implementation program was a nearly exclusively municipal venture. Regional mental health care managers and workers did not participate in the program.

A large part of the interviewees are convinced that the Masterplan will at least further complicate (physically as well as ideologically) communication between regional and municipal mental health workers. However, key persons particularly fear that the plan and the separation of the two mental health care systems in general, will lead to an impoverishment of services for persons with severe mental and social problems and multiple support needs. These interviewees believe that regional psychiatry is becoming too specialized and exclusively biomedical oriented and that municipal mental health care does not have the required expertise on severe mental health problems. Most importantly, while integrated care is becoming ever more essential, it is becoming increasingly difficult to realize¹¹.

11 Some interviewees express the wish to create ACT-teams in Aarhus, for the most vulnerable persons. The division of the mental health care (and funding) system is believed to hinder this plan. The growing ideological separation of the two systems is said to further complicate matters. Some ACT-advocates are opting for funding from the Sats innovation fund, but realize that Sats funding will be on project basis and temporary.

Concerns about persons falling through the cracks of the dual system are reinforced by some other factors. One of these factors is the production pressure in the regional psychiatric system, resulting in an impulse to maximize patient influx and patient turnover. According to some of the key persons, this also leads (and has already led in the past years) to a shift of attention away from persons with severe and long-term problems and towards the much larger population of patients with less severe, short-term mental health problems (see also Aagaard et al., 2008). It is also said to lead to a pressure to diminish time-consuming outreach activities. At the same time some interviewees fear that the recovery-orientation in the municipal system will lead (be it unintentionally) to a focus on the better functioning clients and to a decrease of investments in clients that are considered to have less potential. There are also concerns that the recovery and related social inclusion idiom cannot always escape from the risk of being misused for cost saving motives. Representatives of consumer organizations indicate that for these reasons and because of the relatively rigid top-down implementation, not all clients in Aarhus feel at ease with the current recovery-paradigm. As recovery is considered as an opportunity by many, it is said to be experienced as a pressing obligation by some others.

Finally, concerns are expressed about the degree to which the municipality's mental health care workforce is equipped for its job. Education for the profession of Mental Health Social Worker, which is by far the largest profession in the municipal mental health care system, is relatively low and short. In addition, some interviewees argue that the cooperation with other departments within the municipality has grown since the transfer of social psychiatry, but perhaps not to the extent that was hoped for. Municipal departments in education, work, welfare and social benefits each have their own targets, budgets and nationally regulated funding and accountability systems. Interviewees assure that in the case of persons with multiple problems and support needs, this silo-budgeting and - funding makes it hard to get the other professionals and departments take their responsibilities (more so because acquaintance with the recovery concept has not spread across the municipality). Some speak of a tendency to shift tasks back towards the mental health care system. In general, key persons assure that ultimately solutions are found on an individual level most of the time, but that it is much more difficult to make arrangements on the formal level.

Against this background of high expectations versus serious concerns about the current and future quality of outpatient care and community support for persons with severe mental health problems in Aarhus, the call for a partial reversal of the psychiatric bed reduction of the past decades is currently gaining volume.

Disincentives and barriers to community support from the national policy and system level

Some of the barriers that are currently experienced on a local level in Aarhus stem from national policy and system characteristics. Most important are the assumed disintegrating effects of the dual mental health care system. According to many interviewees incentives of the dual system for discontinuity and incoherence outweigh advantages of local responsibilities for social psychiatry. It is believed that policy makers did not oversee the consequences of the reform. More so, because the transfer of social psychiatry to the municipalities was not a substantiated policy measure in itself but a by-product of a much more encompassing administrative reform. Not all of the key persons are negative about the result, but none are outspokenly positive. Some interviewees point at national figures indicating growing numbers of crisis situations and forensic inpatients, discontinuous care trajectories and even rising standard mortality rates among persons with severe mental health problems in Denmark. Some believe that there might be a relation with decreasing quality of the present mental health care system.

Key persons indicate one other delaying factor and potential barrier to the development of solid community support in Denmark and that is the fact that mental health care and social care budgets are not ring-fenced and required (capacity and quality of) community support services are not specified on a national level. Decisions on service levels have been highly decentralized. This might create opportunities for innovations in prosperous times (although some interviewees point out that for care providers the decentralized system often leads to less instead of more flexibility; acquisition as well as accountability have become much more time-consuming and fragmented). More importantly, many interviewees suggest that decentralized budgetary decision making increases risks of arbitrariness of service levels and the risks of impoverishment of services in times of economic crisis. Service levels between regions and municipalities in Denmark are said to differ profoundly. In addition, experiences in Aarhus show that particularly municipal services are suffering and have already suffered from the current economic crisis. Housing facilities, day activity centers, but also consumer organizations and the recovery project have undergone or are facing budget-cuts¹². Pressure is increasing to shorten patient-stay in housing facilities and other services. Some interviewees suggest that one positive aspect of this development might be the increasing pressure to integrate people in regular community services (regular housing, education, etc.). Others indicate that social inclusion can only be successful with appropriate support to these regular organizations and to clients themselves. They believe that social inclusion is not compatible with the current budget cuts.

Again, concerns are specifically about persons with severe mental health and social problems. First of all because precisely the services for this group are under pressure. Secondly, because budget-cuts also lead to a withdrawal of the regions and the

¹² Consumer organizations are increasingly developing and marketing services of their own.

municipalities and the several departments within the municipalities to their own core businesses. Investments in cooperation and integration of services are descending in the agenda's of the organizations involved.

The economic recession is also said to erode the group and individual entitlements of persons with severe mental health (or social) problems in the fields of housing and work. People have a first right to 25 % of accommodations in public housing, but there is a shortage of affordable houses. Also, companies have an obligation to employ persons with mental health problems, but vacancies are decreasing and job requirements are rising.

To conclude and according to interviewees, the present dual mental health care system, decentralization of decision making and the current economic crisis are serious barriers to the development of comprehensive and coherent community support services for persons with severe mental health problems in Denmark. In addition to that, many interviewees state that national policies contain many good intentions and meaningful steps, but that a consistent, coherent and forceful national approach is missing.

Suggestions for national measures to facilitate and promote community support

Key persons have made a range of suggestions for national measures that could remove current barriers and facilitate and promote the further development of community support. These suggestions can be summarized into four categories:

Vision

According to many interviewees, national government should formulate one clear and consistent vision on community support and social inclusion of persons with severe mental health problems. Central to this vision should be people's wishes to lead a normal life and people's experiences with what is needed to do so. General national economic and social interests in investing in adequate support services for persons with severe mental health problems should also be made clear. The vision should actively be disseminated (among others through supporting anti-stigma programs and an active role of clients themselves).

Framework

A framework of what constitutes an adequate and effective community support system should be described. The framework should be about content, organization and funding and should be as much as possible based on existing evidence of effective arrangements.

Implementation and enforcement

The impression is that interviewees differ in their opinions on the required level of detail and the required level of enforcement of the national vision and framework. Related to the current situation there seems to be a broad consensus, however, that a more directive and enforcing approach is desirable in terms of:

- individual entitlement to housing and work
- ring-fencing of budgets
- investments in the quality of municipal social psychiatric services
- investments in outreach of the region's mental health care system
- promotion of cooperation on all levels (through bonus systems and funding criteria)
- promotion of inclusion in education and work (through bonus systems and funding criteria)
- quality control

Integrated care

"Make sure that clinical treatment and social support go hand in hand. That is absolutely the most important lesson," according to one of the key persons. In general, a significant number of key persons stress the importance of a national policy that promotes integrated care for persons with severe mental health problems, especially for the most vulnerable among them. Some interviewees argued for a reunion of municipal and regional mental health care under one authority. Others doubt whether this is realistic and plead for at least a national prescription of specialized integrated services like Assertive Community Treatment (ACT) and Individual Placement and Support (IPS) (Aagaard & Muller Nielsen, 2011). According to these key persons, funding of integrated services should also be nationally prescribed and organized, if not through a single, reunited mental health care system, then through an obligatory joint financing of ACT and IPS teams by the municipalities and the regions.

National plan

There is a broad consensus among key persons in Aarhus that it would be a good thing to elaborate the topics mentioned above in a consistent and comprehensive national plan for community support.

2.5 Main findings

As we have seen, the current mental health care system in Denmark is the result of both a gradual, long-term process of deinstitutionalization and a radical administrative reform in 2007. The deinstitutionalization process has led Denmark to a relatively low psychiatric inpatient capacity, although the level of residential facilities is relatively high. The structural reform in 2007 has led to a dual mental health care system, where social psychiatric and housing facilities became the responsibilities of the municipalities and the core 'treatment' business of secondary mental health care became the responsibilities of regional authorities. Community support and social inclusion of persons with severe and long term mental health problems are relatively widely attended topics in Danish national policy documents. Several policy measures have been taken in recent and earlier years that should help implement these social inclusion and participation policies. These measures range from individual or group entitlements to innovation funds and the promotion of cooperation between care providers on an individual and a local level.

As Aarhus is concerned, we found that this city has a long tradition in the establishment of support services for vulnerable people. Through the years a range of services has been developed in Aarhus in the fields of housing, supported living, day activities, participation, education and work. As mental health care is concerned, a dual system exists in Aarhus since 2007 (as in the rest of Denmark): social psychiatry is provided by the municipality, inpatient services and outpatient psychiatric treatment and counseling are provided by Aarhus University Hospital, which is controlled by the regional authorities.

Key persons believe that, although there is still a lot to be done, Aarhus had developed a solid base from where to proceed. Traditionally there is a strong consultation and cooperation culture and structure in Aarhus. Consumer organizations are also strongly represented and engaged in activities in Aarhus. In addition, an extensive recovery education and implementation program has been launched throughout the municipal mental health care system in the past years. Those involved believe that the program has had a profound impact on perspectives and activities of professionals and has contributed to a shift of attention towards clients' potentials to lead a meaningful and productive life.

With respect to national incentives, key persons appreciate the regulations for individual and group entitlements of persons with mental health problems in the fields of work, education and housing. They believe that these measures are to a certain extent effective. The same goes for instruments to promote cooperation on an individual and regional level: the obligatory coordination plan for persons with severe mental health problems and the obligatory health agreement between the municipalities and the regions.

But, according to key persons, there are also two important potential national system and policy barriers to the development of comprehensive community support systems. One of these is the dual mental health care system as such. Positive feature of the system is that it shortens the organizational distance between social psychiatry and other municipal departments (education, housing, work). One relativistic remark to this is that also within the municipality the financial, organizational and ideological dividing lines between departments can be strong. More importantly, however, is that the dual mental health care system is believed by many key persons to hinder integrative, comprehensive and continuous care. In fact there is a substantial risk that municipal and regional mental health care in Aarhus will drift apart. Indications are that the recovery education program is an exclusively municipal venture. In the meantime, the regional authorities' mental health care policy is aiming at psychiatric specialization and withdrawal from the community mental health centers that were originally run in cooperation with the municipal social psychiatry. Communication is becoming more difficult physically as well as ideologically. And integrative care is becoming harder to realize. Concerns are that the gaps between the respective systems and services will grow wider and that especially the most vulnerable people will fall through the cracks. Concerns are also that in both the municipal and the regional mental health care system, there are incentives to a shift

of attention away from persons with the most severe mental health problems. These incentives are believed to be in the relatively low education level of municipalities' mental health social workers, in a potential misinterpretation of the recovery-paradigm and in production and patient turnover pressure in regional psychiatry.

The second potential national policy barrier to the development of community support is that decision making on budgets and required services is to a great extent decentralized to the regions and the municipalities. This could be a potential for innovation in prosperous times, but is considered by many key persons as a great risk in current times of economic crisis. Budget cuts are especially taking place in the municipalities support services (sometimes legitimated under a recovery and social inclusion motto). Budgetary tightness also leads to a withdrawal of all parties involved to their core businesses and to disinvestments in cooperation. Finally economic head wind erodes individual and group entitlements in the fields of housing and work. Again, persons with severe mental health problems are believed to be at the greatest risks of suffering from this lack of anchoring of services.

Key persons have made a range of suggestions for national measures that could remove current barriers and facilitate and promote the development of community support. These suggestions can be summarized into five categories:

- establishment and dissemination of a consistent national vision on community support and social inclusion
- development of a national framework concerning entitlements and required support services
- a directive and enforcing approach with respect to implementation (through ring-fencing of budgets, funding criteria, bonus systems and quality control)
- a directive policy concerning organization and funding of integrated care for persons with the most severe mental health and social problems
- integration of the elements mentioned above in a consistent and comprehensive national plan for community support.

3 England - Nottingham

3.1 The English Mental Health care system

The health care and social care systems in England currently are the subject of relatively turbulent policy discussions and developments. These discussions and developments are also expected to affect mental health care, as will be seen later in this chapter. However, turning to the general mental health care system as it has developed in past decades, two features stand out. The first is the relatively strong and directive control of central national authorities over the mental health care system, both in terms of organization and in terms of the services to be delivered. The second is the long-lasting and extensive deinstitutionalization process that has led England's psychiatric inpatient capacity to decline from a relatively high level a few decades ago to one of the lowest compared to other Western European countries in recent years.

Nationally funded statutory services

Statutory mental health care in England is largely part of the National Health Service (NHS), an almost fully publicly funded health care system, under control of the Department of Health. The NHS covers all primary, community and secondary health care. Primary care at the time of the survey was undergoing restructuring but was delivered through 'primary care trusts'. Hospital care, as a part of secondary care, is provided on behalf of the NHS by the so called National Health Service Trusts (NHS Trusts).

The NHS (including its mental health services) is mainly financed through general taxation (76 %; derived mostly from income taxes), but also by national insurance contributions (19 %) and user charges (5%) (Boyle, 2008). With the exception of these 5 % charges (for some prescriptions and optical and dental services), the NHS is free for anyone who fulfils UK residency requirements. The government sets the budget for the NHS on a three-year cycle. In 2008/2009 approximately 14 % of the total health care budget was spent on mental health care, which came down to approximately € 16 billion in total (or € 310 per capita).

The NHS has a history of relatively detailed standards of service delivery and of identifying key interventions that have to be available for defined care patient groups (Boyle, 2008). In this respect NHS Trusts used to be directly responsible to the Department of Health. National standardization and quality measures have also been important elements in the transition of the English mental health care system, from the former hospital oriented, to a predominantly community oriented system. Currently however increasing numbers of trusts have achieved 'Foundation' status, which means effective organizational independence from the Department of Health. Foundation trusts now largely set their own targets for performance measurement and retain their own profits for reinvestment (see also paragraph 3.2).

Secondary mental health care (inpatient and outpatient) is mainly provided by 52 local Mental Health Trusts. Mental Health Trusts in 2008/2009 had a total number of 26,000 psychiatric beds (Harker, 2009), all of these at units or wards defined as providing acute inpatient services. On a total population of 52 million, this comes down to a little more than 50 psychiatric hospital beds per 100,000. For comparison: in 1987/1988 the total number of beds still was 67,000. This means that inpatient capacity has dropped in two decades by almost two thirds. In fact the reduction of inpatient facilities already started, at a modest rate, in the fifties and sixties while recent figures indicate that the psychiatric beds reduction is still going on, at least in terms of occupied beds. While England counted 23,000 occupied beds in 2005/2006, this number was further reduced to 21,000 in 2009/2010.

Mental Health Trusts do not only run acute inpatient services. People with mild to moderate and transient conditions may be referred to outpatient clinics run by the Mental Health Trust. Next to that the Trusts provide a range of ongoing outpatient mental health care services for persons with more severe or enduring mental health problems. In the past ten years these have been organized in several, nationally prescribed types of teams, called collectively Community Mental Health Teams (CMHT's.) These CMHT's together comprise the largest part of outpatient mental health care and serve the largest part of clients with severe and enduring mental health problems. Four types of specialist teams are generally integrated in the general CMHT's. These are: Crisis Resolution teams, Assertive Outreach teams, the Early Intervention in Psychosis teams and the Community Rehabilitation teams. The most intensive care is provided by the Crisis Resolution teams. Patients of these teams are in an acute and severe crisis and would, without the help of the team, need hospitalization. The teams provide a 24 hour home care service and take referrals from a wide variety of sources such as Accident and Emergency (A&E), the police, GP's and general hospitals. Assertive Outreach teams are specifically directed at people with a history of serious mental health problems who are not (or no longer) seeking help themselves. Staff of the Assertive Outreach teams will try to persuade these people to get in touch with mental health services again. Early Intervention in Psychosis teams focus on persons who are between the ages 18 – 35 and are experiencing a first psychotic episode. Community Rehabilitation teams provide community support, training and rehabilitation services for persons suffering from severe or chronic mental health problems.

National production figures and extrapolation of Nottingham figures indicate that the mental health trusts are predominantly staffed by community psychiatric nurses. An estimated two thirds of staff are psychiatric nurses, 5 to 15 % are medical staff (psychiatrists), social workers or occupational therapists respectively, while less than 5 % are psychologists. Production figures indicate that specifically the number of contacts with psychiatric nurses and social workers has grown in the past years.

Funding of mental health services takes place through two channels: health care commissioners and local authorities. Health care commissioners (also for secondary health care)

were until recently stationed at the NHS primary care trusts (PCTs), that controlled around 85 % of the NHS budget (Boyle, 2008). An estimated 80 % of revenues of mental health trusts used to be issued by PCT commissioners. Recently however a series innovations have been launched in the organization of health care commissioning, among others resulting in local clinical commissioning groups taking over commissioning of most secondary health services (see also paragraph 3.2).

National figures indicate that in 2009/2010 over 1.25 million people used some form of NHS specialist mental health service (rate of access of 2,700 per 100,000 population). The use of mental health services has increased by approximately 3 % per year since 2005. The majority of persons using mental health services, use out-patient service (over 90 percent, nearly 12.5 million contacts total). In total in 2009/2010 approximately 108,000 people used inpatient services (a little over 200 per 100,000 population).

Locally funded and non-statutory services

As indicated above, parts of the statutory mental health care services are funded through local authorities. This is specifically the case for services in the fields of housing, community support and participation. Some of these services are provided by the mental health trusts (as are the nationally funded services), but a range of so-called non-statutory organizations is involved. These organizations, known as voluntary, third sector or non-governmental organizations, often include a wider client population (homeless or socially isolated persons). Also, many of these organizations derive their income from other local or national social care or housing budgets, (temporary) innovation funds, charity funds, or other sources, as well as mental health commissioners.

Many residential services for persons with severe mental health problems in England are provided by these non-statutory organizations, often but not always in cooperation with the mental health trusts. Services consist of various types of sheltered and supported housing with various levels of (intensity of) support. Some of these have a nursing staff, others do not. Some facilities have rehabilitative goals, others can be characterized as care homes. According to Priebe et al. (2009) the number of sheltered and supported housing facilities in England has grown from 16 per 100,000 population in 1990 to 24 per 100.000 in 2006 (or from approximately 7,500 to approximately 12,500).¹³

Additional services in the field of community support, day activities (day centers) and participation often consist of a range of various (small scale) projects and facilities, financed through a heterogeneous set of local and national, structural or temporary funding systems in the fields of health care, social care and work. Again, mental health trusts, local council departments and the voluntary sector play a role in these types of

13 Total current inpatient and residential facilities in England would add up to approximately 38,500 places or 75 per 100,000 inhabitants.

services. The well developed consumer organizations in England are also often involved in various projects or have set up activities themselves.

So while mental health care trusts and the NHS are at the core of mental health care in England, other organizations and funds, partly under control of the local authorities, come into play when housing, social care, community support and social inclusion services are concerned. Important to add is that resources in these social fields are considered less solid (often not ring-fenced) compared to regular health care resources. Indications also are that local authorities' autonomy is growing regarding the budgets they spend on these services and the services they fund (Moscone and Knapp, 2005). In this sense current community care and community support delivery and funding for persons with severe mental health problems in England seem to be on the interface of a well defined and still relatively tightly organized national mental health care system (with clear entitlements to consumers) and a much more open social care and participation system, partly controlled by the local authorities, where entitlements are less strictly defined.

As noted earlier, the current system is not a static one. The next paragraph demonstrates that the current situation is, on the contrary, the result of a process of ongoing policy dynamics that recently seem to have changed into higher gear.

3.2 English national policy on mental health care and community support

Much of the past English policy on services for persons with (severe) mental health problems can be inferred from the above. A strongly held policy goal of deinstitutionalization and a relatively strictly defined set of outpatient alternatives to inpatient services have been at the core of developments in England in the past decades. In the past few years policy developments have proceeded in the direction of social inclusion objectives. However, the prescriptive composition of mental health care policy now seems to be making way for a much more liberal one. In addition, mental health care and community support are increasingly becoming subjected to general policy plans for encompassing reforms in the health care and social care systems as such.

Part of these general policy developments in mental health care in England can be illustrated by two contrasting and important national mental health care policy documents of the past 12 to 15 years: the National Services Framework (NSF) of 1998 and New Horizons of 2009 (which led to the more recent No Health without Mental Health of 2011).

The National Service Framework

After the Community Care Act of 1990, which led to an accelerated de-institutionalization process, the National Service Framework (NSF) of 1998 can be viewed as a landmark in the transition process of the former hospital oriented mental health care system, to

a well-defined community care structure. The NSF was part of a set of policy directives for particular areas of care. The mental health care part of the NSF may be held in large part responsible for the current shaping of the mental health care services in England, as it spelled out national standards for mental health (what they aim to achieve but also how they should be developed and delivered) in every part of the country. The NSF standards specifically focused on the development of 'community based mental health care' for persons with severe mental illness. The various current community care teams, as outlined in the previous paragraph, all stem from the drawing table of the 1998 NSF. In addition, the NSF launched policy principles such as the involvement of service users and their carers in planning and delivery of care and the obligations to the mental health care system to promote independence, to enhance coordination between all staff and agencies, and to deliver continuity of care for as long as this is needed.

The implementation of the NSF was done very forcefully and tightly throughout England. In hindsight and with regard to services for people with severe mental health problems, the focus of the NSF might be viewed as one that was predominantly aiming at warranting good quality and accessible community *care* facilities more so than enhancing and promoting participation and social inclusion (community *support*) objectives. The focus was on outreach and crises resolution and on subsequent access to appropriate follow-up outpatient care, as close to home as possible.

However, the implementation of the NSF was accompanied by several additional policy incentives and innovation programs (some new and some already existing), that were relevant for the cooperation of the mental health care system with other sectors, specifically social care and housing.

A keystone of service delivery is the Care Programme Approach (CPA), which was first launched in 1991. It requires that, on an individual level, health and social services jointly assess need, provide a written care plan, allocate a care coordinator (or key worker), and then regularly review the plan with key stakeholders. The CPA has been through two major revisions, refining the eligibility criteria. In 2009-2010 approximately 210,000 persons were 'on the CPS' (the Health and Social Care information Centre, 2011). The Social Inclusion Program also promoted cooperation and coordination between health and social care, but on an aggregated level. The Social Inclusion Program was a national effort to promote social inclusion in general and to encourage cross-departmental and cross-organizational engagement and cooperation in the fields of employment and housing for vulnerable persons in particular. Persons with mental health problems belonged to the identified target groups¹⁴

Also to be mentioned is the Supporting People Program, that was introduced in 2003 and is believed to have had a profound impact on the development of supported housing (see paragraph 3.4). The program consisted of the integration of a formerly

14 Office of the Deputy Prime Minister (2004). Social Inclusion for People with Mental Health Problems.

relatively unorganized collection of grants and funds into a solid, ring-fenced budget for the development of supported housing. The budget of the Supporting People Program was controlled by the Ministry of Housing and was granted through the councils. The program held strict reimbursement criteria, among which the requirement for local cooperation between relevant organizations.

The Social Inclusion and Supporting People Programs introduced a broader social inclusion and community support scope to the service provision of persons with severe mental health problems. Both have ended now (perceptions of their impact and the impact of their termination will be discussed in paragraph 3.4.), but social inclusion became the central concept of *New Horizons*, the new national policy document on mental health care, that was published in 2009.

New Horizons

Introduced as a policy proposal ('White Paper') *New Horizons* emphasized that general principles for a just society and a right to a meaningful life for its citizens also apply to persons with mental health problems. According to *New Horizons* these principles come down to the values of equality, justice and human rights, to opportunities for all citizens to reach their full potential and being in control of their lives and in general to value relationships. In order to realize these principles for persons with mental health problems, a range of specific objectives should guide services and the organization of services. Central to these objectives are social inclusion and tackling stigma and discrimination. Services and interventions should enable persons with mental health problems to engage in meaningful activities and to participate in society, without encountering false and negative imaging. To this end, services should be personalized, recognizing individual backgrounds, histories, environments and preferences and enabling clients to make their own choices and monitor their own processes. Engagement of and support to family and informal carers should become standard procedure. And services should be recovery oriented, recognizing the value of personal experiences and of hope.

Compared to the National Services Framework, *New Horizons* marked a next step by broadening the scope and by embracing a social inclusion and recovery viewpoint. It is not only about care but also about the place in society of persons with mental health problems. It not only addresses mental health care but also the social care, education and employment sectors. In this sense *New Horizons* might be viewed as an emancipation statement. Another important difference between the two policy documents, however, is that, as one of the consulted experts of our study put it, '*NSF talked about structures and targets while New Horizons talks about values and ideas*'. The NSF was in fact a detailed blueprint including an implementation plan, whereas *New Horizons* is more of an inspirational statement, from where the national and local actors and stakeholders themselves should carry on. Also *New Horizons* is not explicitly targeting persons with severe or long term problems. It talks of persons with mental illness in a broad sense, suggesting it aims at a wider population.

The official mental health policy that followed New Horizons, No Health Without Mental Health, emphasizes the concepts of inclusion, stigma and recovery but also contains a strong plea for prevention and draws attention to the mental health of the general population. More concrete, *Time to Change*, the national campaign to combat stigma, was supported. The campaign has been set up in a grand design, including a range of different facets and a range of national and local projects. On a smaller scale the National Recovery Pilot Program is being supported. In this program, a number of sites are assisted in implementing a recovery approach in service development and delivery by and to persons with mental health problems. The project is partly funded by the national government and will be evaluated by the Centre for Mental Health.

Also in line with the latest social inclusion policies are some of the recent policy measures in the field of work. Employment has been added to the outcomes framework of the NHS. Recently several new employment programs have been set up, among which Work Choice (part of the general Work Program), offering specialized support (up to two years) for persons with (mental) health problems. Also contracts have been set up (predominantly with large private companies rather than mental health organizations) to develop and implement IPS on a larger scale.

Important to note is that in the meantime some relevant changes are taking place in the welfare system. First, since the Welfare Reform Act, dating from 2009, individuals with benefit entitlements are more strongly encouraged to find and preserve employment. No longer is it assumed that a diagnosis of mental illness makes a person unemployable. A second relevant development is the introduction of personalized budgets in social care. Funding does not go into general facilities for a specific population but into personal budgets, with which the individual can purchase the (regular) services he or she needs. Finally, several anti-discrimination laws have been replaced in 2010 by a single Equality Act, which aims to help achieve equal opportunities in the workplace and in wider society.

Latest developments: reform plans for the health care and social care systems

Mental health care policy in England has undergone some important changes in the past decade, as is shown above. The latest developments are that mental health care and community support are increasingly becoming subjected to policy plans that encompass reforms in the health care and social care systems as such. At the core of these reform plans are a further decentralization of responsibilities, increasing room for local decision making on service provision, introducing incentives for market competition and increasing involvement of the private sector. A range of concrete measures to implement the reform plans, have already been taken or are in preparation. Quality and price competition is being encouraged by, among other things, preparation of a new reimbursement system in health care, known as Payment by Results (relating payment to the quantity and case mix of activity undertaken). PCT commissioners are stimulated to contract services from private providers. But also, more radically a transfer is taking

place from nationally guided PCT commissioning to local commissioning consortia of clinicians. Another element of the reform plans is the transfer of responsibility from public health to local authorities.

As a result of these reforms, it is believed that the position of the National Health Service Trust is moving from that of a statutory, nationally controlled institution to a relatively independent foundation that has to compete for its market shares.¹⁵ Especially precarious to the reform plans, besides the political dimension, is the fact that they are being launched and implemented in economic harsh times, and coincide with sometimes drastic cutbacks in public expenditures, particularly by local authorities. This seems to boost the discussions on the possible consequences of the reform plans (see also paragraph 3.4).

For the time being, we conclude that mental health care in England has received much attention from national authorities and is greatly influenced by national policy over the past twenty years. In particular community care is a longstanding and strongly enforced objective in English mental health care policy. We also conclude that recently objectives have been expanding to community support, recovery and social inclusion, but at the same time implementation in these fields is less directive. Also health care and social services – and public services in general – have become the subject of relatively drastic reform plans and of intensive national debate.

In paragraph 3.4 the judgments of the consulted experts and key persons will be discussed on the impact of past and current policies and system characteristics on the development of community support for persons with severe mental health problems. Before we get to that, we present an overview of mental health care and community support services in the region of Nottingham.

3.3 Characteristics and community support facilities of the Nottingham region

The English region that this study focuses on is the city of Nottingham and its surrounding area Nottinghamshire County. Nottingham is located in central England. Approximately 1.1 million people live in the area, of whom almost 300,000 in Nottingham city¹⁶. The region covers 2160 square kilometers (495 inhabitants per km²). Nottingham city and Nottinghamshire County each have separate local authorities (councils).

15 There are also restrictions to the new 'market' system though. One of these restrictions is that commissioning by the new consortia will not be totally free in a geographical sense but will take place on the basis of well-defined geographical regions ('coterminosity').

16 Sizes of the age groups are: 248,500 (23 %) <20 year, 652,000 (61 %) 20-64 years and 170,000 (16 %) > 64 years.

Nottingham city ranks 12 out of 354 communities on lowest average score on SES-indicators. It specifically ranks high on proportion of population in multiply deprived areas. Nottinghamshire county ranks 92 on lowest average SES-scores, but is relatively high (even more so than Nottingham city) on indicators for income and employment deprivation (www.communities.gov.uk/indices).

In our study, when we speak of Nottingham, we are referring to the region of Nottingham city and Nottinghamshire County, unless stated otherwise.

Mental health care in Nottingham

The main provider of secondary mental health care in the region is Nottinghamshire Healthcare NHS Trust (NHCT). The catchment area of the trust's 'regular' mental health care is the region mentioned above: Nottingham city and Nottinghamshire County. However the NHCT does have a very large forensic department with a much wider catchment area (and an estimated 1/4 of total NHCT capacity).

Mental health care services of the NHCT are provided from more than 100 sites by 6,000 staff¹⁷. The staff of the NHCT are mostly psychiatric nurses (59 %) and social workers (23 %). The total revenue over 2010 was € 345 million¹⁸. Funding is mostly issued through the three Primary Care Trusts of the region and for a small part through the two local authority councils¹⁹. An estimated 20,000 working age adults receive services from the NHCT on an annual basis²⁰.

The (non-forensic) mental health care services of the NHCT are provided in a range of settings, in accordance with national standards for the availability of mental health services (see paragraph 3.1). Directly notable, however, is the low capacity, even to English standards, of acute inpatient services. Acute inpatient facilities are provided in 7 locations and count a total number of 203 acute beds. This comes down to 20 beds per 100,000 population, which is much lower than national average and drastically lower than Western European average.

NHCT outpatient and home care services for people with mental health problems are generally provided by the community teams as mentioned in paragraph 3.1, although changes in service structure and titles are taking place. Data of 2010 show that outpatient mental health care for adults with severe and enduring mental health problems at that moment consists of:

17 Excluding forensic services and premised that these comprise ¼ of total capacity, these figures come down to approximately 450 staff per 100,000 inhabitants.

18 Excluding forensic services and premised that these comprise ¼ of total revenues, these figures come down to approximately € 260 per 100,000 inhabitants.

19 Nottingham City PCT, Nottinghamshire PCT, Bassetlaw PCT, Nottingham City Council and Nottinghamshire County council.

20 Uncorrected for the wider forensic catchment area, these figures would come down to approximately 3,000 clients per 100,000 inhabitants.

- Community Rehabilitation teams, recently renamed Recovery teams (188 fte) providing general outpatient mental health services to more than 5,000 clients (point prevalence) (caseload approximately 1:30).
- Assertive Outreach teams (64 fte), providing outreach services to more than 400 clients, mostly persons with severe problems (caseload 1:8). Recently, Assertive Outreach teams of the NHCT have been integrated with Community Mental Health / Recovery teams.
- Crisis Resolution Home teams (109 fte), providing high-intensity services to almost 200 clients in acute crisis situations (caseload 1:2).
- Early Intervention in Psychosis teams (51 fte), providing services to almost 500 persons with a first episode or suspected first episode psychosis (caseload 1:10).
- Rehabilitation / Continuing Care teams (50 fte), providing training and rehabilitation services to almost 600 clients suffering from severe or chronic mental health problems (caseload 1:10).

In addition, there are two so-called outpatient clinics: one traditional consultant clinic and one 'step forward', recovery oriented clinic.

Housing accommodations and supported housing in Nottingham

The NHCT also provides several types of housing accommodation for persons with long term mental health problems. These are mostly 'residential rehabilitation units' and '24 hour nurse staffed care' facilities. In total there are an estimated 183 beds in the 16 NHCT-run housing accommodations in the region (18 per 100,000 population).

However, housing is also provided by other organizations. Especially Framework is a relatively large non-statutory organization, that not only provides short-term housing, but also supported housing to vulnerable people, including persons with severe mental health problems. Framework has its base in Nottingham but has a catchment area that extends the Nottinghamshire county. It is the largest provider of 'support in housing' in the region. On a yearly basis approximately 7,000 persons are being assisted by Framework. An estimated 40-50 % of Framework's clients have mental health problems.

Services of Framework range from hostels, and move-on houses to 'floating support' (helping people in their own homes). Emphasis is on informal, low-threshold, practical and social support, including assistance in finding and preserving employment. Finances for the accommodations and support services come from a range of resources, including housing benefits and health care and social care funds of the local authorities, fundraising and out-of-pocket payments. In the past decade the Supporting People Program, mentioned in the previous paragraph, has been an important accelerator of the development of Framework's housing related support in the Nottingham area.

Framework and the NHCT cooperate on a formal and informal basis. This cooperation has, among others, resulted in a jointly run housing service for persons with severe and

long-term mental health problems. The service consists of clustered accommodations with intensive, 24-hour health and social support, that is also available for persons in a number of individual apartments in the close neighborhood. Clients are for a large part formerly institutionalized mental health care clients.

Next to Framework and the NHCT, some other, smaller organizations offer specific services in the field of housing support for persons with mental health problems as do some general housing corporations.

Support services in participation

In addition to the services mentioned above, a range of community support services has been developed in Nottingham in the fields of day time activities, education and employment. Several organizations are involved in these services, including the local councils (for funding and partly also service provision), voluntary organizations, consumer organizations and again the NHCT and Framework. Important to note is that many of these services are dependent on temporary programs or project subsidies. Services in this field are also affected by changes in funding systems and budget cuts in social care.

One significant example is the recent closure of day activity- and drop in centers for persons with mental health problems, previously funded by the local authorities. These services are replaced by a system of personal budgets that can be spent on a variety of regular services in the community. How many persons with severe mental health problems meet the criteria and make use of these budgets, is not clear.

Still, for specialized individual support in community participation and vocational rehabilitation, people with mental health problems can appeal to several services. One of these is the Social Inclusion and Well-being service of the NHCT. This department of the Trust has a staff of 35, including a wide range of disciplines. It offers personalized support in work, education and other activities, peer support groups and consultation to other NHCT-teams. The largest part of the Social Inclusion and Well-being Services is funded through the health system. Health care funding is currently under pressure though, and efforts are being made to turn towards mainstream resources of the Department of Work and Pensions.

For employment support, the Trust counts five employment specialists ('Employment Connection Team'). Those working for the city have recently started to provide IPS. The IPS project is partly funded on a temporary basis by a research grant at the University of Nottingham. NHCT-employment specialists also work in other parts of the county, but the NHCT does not provide IPS outside the city. Next to the NHCT, Framework is also offering employment support for persons with mental health problems, specifically in the rural region around Nottingham city. These services are provided by a temporary project called Helping Hands, counting six employment advocates and funded by the department of Work and Pensions on outcome basis. Framework also initiated some social enterprises in the Nottingham region.

Regular employment support services are available from the local Job Centre Plus (JCP) offices (part of the government Department of Work and Pensions). The JCP offices provide benefits assessments and support in finding work for persons with a disability.

Next to the services mentioned above, a range of small scale activities is taking place in Nottingham in the field of social participation, day activities and community networking. The NHCT hosts a special team of support time and recovery workers (STAR; approximately 5 fte). It also has a team of community development workers (approximately 4 fte) whose task it is to increase community engagement by supporting the development and exchange of information, knowledge and skills between mental health services and other organizations in the communities. Another example is MIND, a private organization that provides several small scale services in the field of carers support, befriending, volunteering schemes and day activities. Also the councils provide several carers support services and facilities for user groups. And in the field of advocacy and self-help a range of activities is undertaken by local user organizations (Nottingham advocacy group, AWAAZ, Self-help Nottingham, Speaking up, Making Waves).

To sum up a range of community support services is available in Nottingham. It can also be concluded that services are relatively fragile when it comes to funding. The total capacity of specialized support services in the field of social participation, education and work also seems to be small, compared for instance to the overall capacity of the Trust.

Notwithstanding these limitations, Nottingham is generally being viewed as a leading region when it comes to social inclusion of persons with severe mental health problems. It is also considered a leading region in terms of recovery-orientation.

Recovery

Several factors have contributed to the relatively strong recovery orientation in Nottingham. Leading persons in the national British recovery movement have their home base in Nottingham. A non-statutory but important regional organization like Framework has an approach that is considered to have been supportive of the dissemination of a recovery-oriented attitude and practice in the region. Also consumer organizations and consumer advocacy are relatively well-developed and have long traditions in Nottingham.

One of these organizations is Making Waves, one of the larger consumer organizations in the region. Making Waves operates on the basis of a rather critical position towards traditional mental health care. It has a range of advocacy activities but also offers services to persons with mental health problems and to other organizations, including the Trust. These services include peer support training (for persons with mental health problems who are being employed in the Trust as peer support workers), services evaluations and courses in regular training programs (nurses, social workers). Making waves also initiated several anti-stigma activities.

In the Trust, an ambitious program has been set up in 2009, aiming at the implementation of recovery through the introduction of 'recovery action' plans, training and employment of peer support workers and training of NHCT staff. In 2011, a Recovery Education Center (REC) was opened. The REC organizes a range of consumer-run (group) activities around topics and goals that are chosen by participants. In practice and in line with the core developmental approach of the REC, the emphasis is on topics like work, education, confidence, health, sports. Next to the REC, the Involvement Center, consisting of clients and family, is an important vehicle for consumer perspectives within the NHCT. The Involvement Center is primarily engaged in decision making on an institutional level (for instance staff recruitment).

Nottingham is one of the regions that participates in the national Recovery Program, from which several of the activities mentioned above are financed. Also the employment of peer support workers is (partly) financed through the national Recovery Program, be it under the condition that these peer support workers are offered permanent contracts when the Recovery Program and its project subsidies end.

Cooperation and coordination

Concerning the overall organization of community support and social inclusion of persons with severe mental health problems in the Nottingham regions, there is to this point no specific central coordinating, planning or policy agency or a joint plan of relevant stakeholders. Still, there is a lot of cooperation on several levels and working relations are said to be positive, in general. For instance, PCT (health care) and council (social care) commissioners engage in joint needs analyses and strategic planning. The NHCT and Framework have close working relations on management and service level and have a formalized partnership, including joint services. In addition, Framework has a tradition of community networking, engaging community facilities, local health care and social care agencies. The Trust has, among others and next to their regular working relations with local organizations, set up its team of community development workers.

However, while working relations are good, it is also concluded that more could be done. In 2009, the Local Services division of the NHCT prepared a 'social inclusion strategy', in which the need for regional co-ordination and management of community support services and social inclusion efforts, is outlined. It proposes that key partners form the basis of a Multi-agency partnership, so as to create the right environment for inclusion for people with mental health problems. Key partners in this agency would include, besides the Trust itself, local authorities, local (municipal and voluntary) organizations in the fields of housing, benefits, leisure and work. Also a comprehensive social inclusion program is proposed, consisting among others of a recovery program, a community engagement program, an anti-stigma program and a vocational services program.

Some elements of the program have actually been put into practice. Among these elements is, for instance, an anti-stigma campaign, carried out by the NHCT in coopera-

tion with other local organizations in 2010. Research on its results point out that mental health services users experienced a positive shift in public attitude since the campaign (Schneider et al., 2011). However, the ambition of the Social inclusion strategy as the start of a comprehensive and well-coordinated inter agency venture does not seem to have been fully realized as yet.

3.4 Regional key persons' perspectives on incentives for community support

Perspectives on the achievements, eventual shortcomings and future challenges of the local community support system in Nottingham were further examined and discussed in a series of individual and group interviews with approximately twenty key persons in the local community support network (see appendix). Interviewees represented the full range of relevant (professional and client) organizations and services in the domains of mental health home care, housing, participation (education and work), recovery and coordination and planning. Next to the local situation, specific focus in the interviews was on the incentives and disincentives of the national policy and mental health care system on the development of community support and social inclusion.

It should be added beforehand that the interviews in Nottingham took place in the midst of a period of violent national discussions on the reform plans of the national government. Also permanently on the background were worries about the impact of budget cuts of the local authorities. As a consequence, there was an atmosphere of anxiety in many of the interviews, especially in the closing series of group discussions.

Community support achievements in Nottingham

Notwithstanding these concerns (that will be discussed later), key persons in general believe that a lot has been achieved in Nottingham over the years. General opinion is that the region has long been and still is a precursor of progressive developments in community care and social inclusion in the UK. Illustrative of this tradition is, for instance, that assertive outreach - visiting people in their homes, with small caseloads - was already done in Nottingham in the '80s, before governmental policies stimulated to do that. Illustrative is also the relatively strong impact of consumer organizations in the region through the years.

According to interviewees, several concrete achievements can be seen in the community support network as it currently functions. A solid system of outpatient mental health care teams has been established. Indications are that many of these teams have good results. For instance, according to those involved, the EIP (Early Intervention in Psychosis) teams succeed in reaching high engagement-figures (90 %), good vocational outcomes (50 % of clients enrolls in education or becomes employed) and low suicide-rates (compared to national standards). They also succeed in reaching an ethnically diverse group (including

family and friends of clients). In the field of housing and housing support the NHCT and Framework have developed a range of services that helps persons with severe mental health problems (and others, in the case of Framework) to achieve and maintain good living conditions. According to interviewees the 24 hours housing service for previously institutionalized persons, jointly run by the NHCT and Framework, proves to be very successful (for instance in preventing admissions) and is highly valued by other parties (PCT). The development of the Social Inclusion and Well-being team and the vocational rehabilitation services of the NHCT (IPS) and Framework are said to have led to an increase in people getting back into work. Another positive feature is the local anti-stigma campaign, that resulted in a registered positive shift in public attitude towards persons with severe mental health problems.

Next to that, it is pointed out that Nottingham has gained a leading role in the implementation of recovery-orientation, as one of the demonstration sites of the national recovery program. The latest achievement in this field is the recently installed Recovery Education Center, that is active within and outside of the Trust and attracts a substantial clientele. It is suggested, however, that one of biggest achievements is that - thanks to the activities and developments mentioned above -, and albeit slowly, attitudes towards persons with severe mental health problems and towards their social inclusion and recovery, are changing in Nottingham. According to interviewees these changes are taking place within the mental health care system as well as in the wider community. The spreading of personal contacts with and personal stories of persons with severe mental health problems, are believed to be crucial to that. As a result, confidence in the feasibility of recovery and inclusion is gaining ground among persons with mental health problems, their family and friends as well as professionals in Nottingham.

Positive community support incentives from the national policy and system level

According to key persons, national policies of the past decades in general have helped a lot in achieving the results reached thus far. Mental health care as such has received much attention in national policies over the years. There is a broad sense of continuity and development in national mental health care policy. Also the system of the National Health Services and the directive policies of the National Services Framework are believed to have contributed to the development of a solid system of community care services for persons with severe mental health problems.

A footnote to this is that the NSF is particularly valued for its contribution to the establishment of a general structure for community care, more so than for its substantive vision or for its emphasis on wider social inclusion goals. However, these latter subjects have gained policy attention in subsequent years and became central issues in more recently launched policy papers like *New Horizons* and *No Health without Mental Health*. In these documents, not only (mental health) care, but also social care, education and employment are addressed. Also, recovery as a central concept in service

provision is being promoted. One of the interviewees asserts that, with these recent policy papers and their emphasis on wider social inclusion, empowerment, emancipatory and recovery goals, “for the first time ever we got absolute consistency between what policy is commanding and what people want who have themselves experienced mental health problems”. In general, key persons agree that these policy developments and statements have helped a lot to create the atmosphere where new initiatives in community support, social inclusion and recovery in Nottingham have been able to evolve in recent years.

Interviewees also mention some specific policy measures and instruments that have been helpful in the past decade, some of these measures and instruments not being restricted to mental health care. Positive remarks are especially made about the impact of the (temporary) funding projects of the Social Inclusion Program and the Supporting People Program. The combination of solidly ring-fenced (sometimes cross-departmental) budgets in the field of (supported) housing and employment with the funding requirements of local cooperation between relevant organizations, is considered to have been very fruitful and constructive to the development of community support services, also in Nottingham. Because of these and similar incentives, health care and social care are also said to have grown towards each other in the past 15 years, on a commissioning as well as on a provider level (for instance by stationing and employing social workers, funded by the councils, in the mental health trusts).

Most interviewees also notice that the national anti-stigma campaign Time to Change has its effects and contributes to changing attitudes on a local level. In addition, key persons envisage new opportunities (and some of them are grasping new chances) springing from the growing national policy attention for employment (and IPS) and from the national recovery program and current policy attention for recovery in general.

In conclusion, key persons believe that the development of community care and community support for persons with severe mental health problems in England has profited from several positive national incentives in the past decades. Especially the directive approach through clear funding criteria (in structural funding as well as in temporary innovation funds) is believed to have paid off. Key persons also believe that the objective of social inclusion has gained new momentum by more recent national policies.

Still, concerns are growing that barriers are increasing to use this momentum to the full potential. These concerns specifically target recent policy developments concerning the health care and social care systems in general. Worries are expressed that there might even be a substantial risk of deterioration of what has been built in the past years. According to some, this deterioration is already taking place at some levels.

Barriers and future challenges in community support in Nottingham

Current challenges to further advances in community support and social inclusion of persons with severe mental health problems in Nottingham, can be summed up in two main categories. The first has to do with the persistence of a restrictive medical and nursing approach in mainstream mental health care; the second with the fragmented and non-structural funding of services in social care and social support and the consequential vulnerability of these services in times of economic relapse.

Traditional mental health care

According to some of the interviewees - and notwithstanding the social psychiatric tradition and recent initiatives in recovery - basic values, ideas, practice and organization in mainstream mental health care in Nottingham are still dominated by an emphasis on psychiatric diagnoses, symptoms and psychiatric treatment (medication). Also the main focus in the greatest part of outpatient care for persons with severe mental health problems is said to still be restricted to keeping an eye on people's basic mental health condition, home situation and safety, instead of on recovery issues. Interviewees have the impression that there is still a lot of work to be done to counter overprotective attitudes, based on negative expectations of mental health care workers themselves. Some also have the impression that 'community development' could be put higher on the mental health care system's agenda, as, for instance, community nurses often have little or no connection with the communities in which their clients live. Some also believe that on a managerial level responsibilities of mental health care are still considered to be restricted to treatment of psychiatric disorders and do not include attention for or assistance in social and employment matters. Moreover, voluntary organizations in social support and employment in Nottingham have the impression that there are still important steps to be taken before they are genuinely being perceived as serious partners by statutory mental health care.

Some interviewees also have doubts about the current status of the recovery-concept within Nottingham's mental health care system at large. Some believe that the concept is not yet taken seriously in all mental health care departments and professions. And where it is, it is often considered as icing on the cake rather than a different approach as such. Interviewees also suggest that close attention is needed to the risk of inflation of the recovery-concept, as a growing number of services adopt a recovery-title. Some of these services have relatively high thresholds for admission. The growing emphasis on employment and individual requirements to reach employment goals is also commented on by some interviewers. They point at the risk of recovery becoming a context-free concept, centering around individual achievements (and individual failure) and contributing in itself to the internalization of complex economic, social, psychological and biographical problems²¹. In addition, the use of the recovery-concept as a motivation

21 The same comments are made regarding the local and national anti-stigma-campaigns. It is stated that, for instance, by speaking in terms of mental *illnesses*, the campaigns shift economic, social and biographical contexts of mental health problems to the background and are thus at risk of contributing to stigma rather than diminishing it.

for decisions that are at least in part political (for instance the closure of day centers), contributes to the risk of a decline in the popularity of the concept, among persons with severe mental health problems themselves.

On a structural level some interviewees also question the consequences of the differentiation and specialization (and, according to some, fragmentation) of outpatient mental health care in several specialist outpatient teams. "We have a very complicated system," as one of the key persons puts it. As a result of this (still ongoing) specialization process, the system is believed by some to be at risk of turning inward instead of opening up to the wider community.

Fragmented social care funding

The other main barriers to overcome, next to some central features of traditional mental health care, have to do with the fragmented and often temporary funding of services in social care and social support. Especially funding of services in the fields of supported housing, social support, community development, social networking and specialist assistance in education and employment (IPS) are dependent on a mixture of temporary resources. These resources range from the councils and statutory health care and social care institutions to local and national innovation programs, charity funds and other project subsidies. This dependency on fragmented and temporary resources endangers the continuity of services. Projects are often forced to stop (and sometimes replaced by others) just as a decent knowledge base and a skilled workforce has been developed. At the same time, the broad introduction of competitive tendering increases the necessary administrative and bureaucratic investments in getting or continuing sufficient finance. Large scale national organizations with no specific local bonds are believed to be in an advantageous position in this tendering process, compared to smaller, locally embedded organizations.

Vulnerability of service funding particularly entails high risks in times of economic relapse. In all group discussions of this study, it was unanimously pointed out that Nottingham currently witnesses exactly the harsh consequences of that risk. Heavy budget cuts are said to be taking place in the (supported) housing services of Framework. These services have been built with the help of the national Supporting People Budget, distributed through the councils (paragraph 3.2). That budget has recently been drastically cut back on a national level. In addition, the budget is no longer ring-fenced. Nottingham is one of the councils that chose to drastically reduce funding of (supported) housing services. It is said to have done so much more radically than many other councils in England. As a consequence, many of the services that have been developed in the past decade, will have to be shut. Estimations of Frameworks services that will have to end, range between 40 and 50 %.

Key persons also point at the closure of the formerly council-funded day-centers. Some interviewees indicate that these are replaced by personalized budgets. Others have heavy doubts about the number of persons with severe mental health problems that will apply for or are entitled to these budgets. (Some also question the practicability

and appropriateness of personalized budgets for the social inclusion of persons with severe mental health problems, especially in times of budget cuts on social and public services in general.) In the meantime, vocational services of the Trust (IPS) have very unstable funding while the employment services of, for instance, Helping Hands only have temporary project funding until mid-2012. Moreover, at the time of the group discussions there is talk of the possibility that the locally funded social workers will be pulled out of the multidisciplinary mental health care teams.

Discussing the current downsize of community support services for persons with severe mental health problems in Nottingham, key persons speak of “budget cuts on an unprecedented scale”, resulting in “traumatic times” and “a big waste”. More so because, as said, budget cuts are also taking place in general social and public services. Many interviewees believe the measures to be short-sighted, as they expect them to result in increasing levels of homelessness, psychiatric hospital admissions, ineffectiveness of services in general and, ultimately, raising public expenditures in benefits and acute care. This is especially considered a waste because previous developments in policy and practice in England in general and Nottingham in particular, had reached the momentum where community support could become a genuinely including and thereby cost-saving enterprise. That momentum is believed to be at risk of being turned into an unfortunately missed opportunity.

Disincentives and barriers to community support from the national policy and system level

Current barriers and challenges in the development of community support in Nottingham, as outlined above, partly follow from specific local circumstances. However, system characteristics and developments on a national level are also for a large part responsible for the pitfalls and setbacks that are being experienced at this stage. This is especially true for the relatively fragmented and vulnerable financing structure of social care and community support services, which is a nationwide (and, for that matter, international) phenomenon. It is also true for the budget cuts that are taking place in these domains as a result of national (and again international) political-economical developments.

In addition to that, many key persons in our study have concerns about the consequences of the wider national reform plans in health care and social care. As noticed in paragraph 3.2 the reforms center around a decentralization of responsibilities, increasing room for local decision making on service provision, introducing incentives for market competition and increasing involvement of the private sector. Transfer of PCT commissioning to local commissioning consortia of clinicians is also part of these reforms.

Some key persons believe that these developments may create new opportunities for local initiatives. However, when it comes to community support for persons with severe mental health problems, most interviewees also envisage some important, additional risks for service levels and for coordination and coherence of services.

Risks for service levels

Health and social care in England have traditionally been for a large part delivered according to national standards and nationally prescribed service levels. Decentralization of responsibilities and an increasing room for market incentives and private parties, will result in greater geographical differentiation of service levels and greater differentiation in quality of different types of services. There is a great risk, according to interviewees, that especially services on the interface of health care and social care (community support services) will become extra vulnerable, as no agency, when left to choose, might want to take responsibility for these services. It is added that this risk increases when it comes to services for the most vulnerable and least assertive persons (among whom many persons with severe mental health problems). In a decentralized, competitive system, attention of service providers is expected to shift to more profitable and more promising clients (especially as funding is increasingly based on service outcomes). Some interviewees believe that the latest national policy documents on mental health care (*New Horizons* and *No Health without Mental Health*) add to this shift of attention away from persons with severe and persistent problems and towards the general public²². Moreover, confidence that these documents will prevent deterioration of services for persons with severe problems, is hindered by their alleged non-prescriptive (“vague”) character (as opposed to previous policy documents on mental health services for persons with severe mental health problems)²³.

In summary, key persons state that the vulnerability of community support funding for persons with severe mental health problems is not addressed by current policy plans, but will in fact be increased by the transfer of responsibilities to the local level and to the market. They also believe that, were this transfer to have a chance of positive outcomes for this group, it has further diminished due to the simultaneity of these policy measures and the general cutbacks in public expenditures.

Some interviewees fear that, as a result of these developments and notwithstanding inclusion rhetoric, a repressive practice will regain ground in mental health care (some believe it already has, in the form of a growth of forensic psychiatric services). The wish for risk management and risk aversion is a constant undertone in public discussions and expectations of mental health care. Helped by the media, individual incidents can have large implications, up to the political level (because of the governmental health care system).

Coordination and coherence of services

Next to the risks for service levels, the reform plans are believed to put an extra challenge to the requirements of coordination and cooperation.

22 Some interviewees have the opinion that the national anti-stigma-campaign “Time to change” also contributes to an unbalanced focus on relatively mild mental health problems at the cost of attention for persons suffering from severe and chronic impairments.

23 Whereas the National Services Framework has been typified as a structure without a content, *New Horizons* is being typified as a content without a structure.

Cooperation and coordination are believed to be crucial for coherence and continuity of care for persons with severe mental health problems. Moreover, the need for coordination will keep increasing as the social inclusion process goes together with the involvement of a growing range of community services, each with their own goals and legislative and funding backgrounds. Cooperation, especially between health care, housing, social care and employment (and between PCT and council on a local level), has grown into a golden standard in the past decade. It has been enhanced and enforced by national policy measures.

However, most of these measures are no longer operative (many of them were temporary in the first place). Moreover, competitive incentives are introduced and local connections between health care and social care are loosening, due to budget cuts and changes in the commissioning systems. Key persons question what will be the effect of these developments on the level and quality of cooperation and coordination between service providers (and between funding agencies). Interviewees notice that a joint approach in mental health care and social care commissioning is already becoming increasingly difficult. They also notice that, as a consequence of system changes and budget cuts, some providers have started retreating to their core businesses, protecting their own domain and refraining from costly investments in cooperation (unless predictably profitable for themselves). Also, while silo-budgeting across sectors might partly be inevitable, no mechanisms are in place any more to compensate for the fact that improvements and gains in one sector (for instance employment) might need investments in another (health care). And so, as individual interests are drifting away from the general social and economic interest of social inclusion, investments in the further development of local community support systems are at risk of lacking behind. Moreover clarity about key problem ownership is diminishing on a regional as well as a national level.

Suggestions for national measures to facilitate and promote community support

Key persons in Nottingham have made a range of suggestions for national measures that could remove current barriers and facilitate and promote the further development of community support. These suggestions can be summarized as follows.

First of all, key persons believe that a broad and genuine acknowledgement on national government level is required of the social and economic benefits of community support and social inclusion of persons with severe mental health problems, not only for those involved but for society as a whole. This acknowledgement should not be restricted to the health care department but should have cross-departmental and broad political support. This broad support should help to line up policies and to prevent one department from offsetting what another is promoting. It should also lay the foundation for investments that do not have a direct pay-off for the investing department but do contribute to benefits in other departments and in society in general.

Next, many key persons plea for a continuation, at least in this field, of the directive mode of national policy making of the past one or two decades. Interviewees especially plea for the preservation of what has been built, particularly since the National Services Framework. Next to that, they plea for elaboration of the more recent recovery and inclusion policy ideals into a forceful and directive implementation plan.

At the core of this plan should be a solid funding of community support. Especially flexible, long-term and coherent support in independent living, social contacts, education and employment should have a solid (possibly joint interdepartmental) funding that is ring-fenced and structural. (Some interviewees also believe that the budget for these services should be doubled compared to current expenditures.) Such a funding system should be backed up by general funding prerequisites for statutory organizations and by a range of stimulation and innovation programs. General funding prerequisites can be used to promote local partnerships, recovery implementation and local social inclusion policies. Stimulation and innovation programs could give the incentives to several specific aspects of the development of community support, for instance re-education of mental health care staff (now predominantly nurses) into care support workers, projects to bring local community and persons with severe mental health problems together (community development) and investments in service coordination on a local level.

In essence, most key persons in Nottingham believe that there are no fundamental economic or organizational impediments to the realization of adequate community support and genuine social inclusion of persons with severe mental health problems. They do believe that there is still a lot to be done and that the crucial factor for the realization of social inclusion goals, is the political willingness on a national level to take the required steps.

3.5 Main findings

As we have seen, an extensive deinstitutionalization process in the past decades has led England's psychiatric inpatient capacity to become one of the lowest in Europe. Community alternatives have been developed in the course of directive and prescriptive national policies and consist of general community mental health care and specialist teams for early intervention, assertive outreach, crisis resolution and community rehabilitation. Outpatient mental health care is provided by the regionally organized, statutory mental health trusts. The trusts are part of the National Health Services (NHS), an almost fully publicly funded health care system, under direct control of the Department of Health. NHS-funding of the mental health trust goes for the largest part through regional health care commissioners and for a small part (social care) through the local authorities.

Community support in the fields of housing, independent living, social contacts, education and employment is provided by the trusts and by non-statutory, non-governmental organizations. These non-statutory organizations draw their incomes not only (and often

not at all) from mental health care funding, but also from other local or national social care or housing budgets, (temporary) innovation funds, charity funds or other sources. In the past decade some large scale national innovation programs and funds have been important in the development of community support.

Also in the past decade mental health care policy in England has moved from a directive approach, aimed at the development of a solid community care structure, towards the promotion of wider social inclusion and recovery goals. Illustrative for this policy development are the introduction of a comprehensive national anti-stigma campaign and a national recovery-program. Lately mental health care and community support are increasingly coming under the influence of broader reforms and reform plans for health and social care. At the core of these reforms are a transfer of responsibilities to the local level and the introduction of market incentives.

As far as Nottingham is concerned, a strong tradition in social support for vulnerable people and a strong consumer movement stand out. Throughout the years a solid system of outpatient mental health care services has developed, including several social services. In addition, the non-statutory sector has been to a great extent (co-) responsible for the development of services in the areas of (supported) housing and participation (including support in finding and preserving employment). Good relations and joint planning of health care commissioners and local social care commissioners have helped this development. Nottingham is also considered a national precursor in the introduction and implementation of a recovery-approach in service provision. It has opened a Recovery Education Center in 2011. It also participates as one of the pilot sites in a national recovery promotion program.

According to key persons in Nottingham, national policies of the past one or two decades have helped a lot in realizing the community care and community support services that have been developed so far. It is widely appreciated that attention for mental health care on a national policy level, has in general been extensive throughout the years and has developed in a relatively coherent and consistent manner. Especially the directive approach through clear funding criteria (in structural funding as well as in temporary innovation funds) is believed to have paid off. For instance, the National Services Framework of 1998 has helped create an adequate system of community mental health care. Specific innovation programs in the fields of (supported) housing and employment combined solidly ring-fenced (cross-departmental) budgets with the funding requirements of local partnership; an approach that has been successful in the development of community support services, also in Nottingham. Key persons also believe that the policy objective of community support has gained content by more recent national policy documents on social inclusion and recovery.

There are concerns, however, that these new policies are lacking solid implementation plans, while existing barriers to social inclusion are not fully addressed and impediments

are even increasing. Key persons specifically point at the vulnerability of the fragmented and non-structural funding of community support services at the interface of health care and social care, especially in current times of economic relapse and especially when it concerns services for vulnerable and non-assertive people. As a matter of fact Nottingham currently witnesses severe budget cuts in this area, especially in supported housing. Day centers have also recently been closed (the status of individualized alternatives is not clear yet). An additional concern at the time of the interviews was the potential retraction of the locally funded social workers from the multidisciplinary mental health care teams of the trust.

Concerns are also expressed that the vulnerability of community support funding for persons with severe mental health problems will in fact be increased by current reform plans and by the transfer of responsibilities to the local level and to the market. The reforms might result in individual interests drifting away from the general social and economic interest of social inclusion, thereby discouraging investments in the further development of local community support systems and in cooperation and coordination. Moreover, due to the latest reform plans, clarity about key problem ownership regarding community support and social inclusion is believed to be fading away on a regional as well as a national level.

Interviewees suggest that these scenarios can be avoided and the development of community support can be enhanced through the acknowledgement on a national government level of the social and economic benefits of social inclusion of persons with severe mental health problems, not only for those involved, but for society as a whole. To line up policies, this acknowledgement should not be restricted to the health care department but should have cross-departmental and broad political support. Next, many key persons plea for a continuation of the directive mode of national policy making in mental health care of the past one or two decades. They plea for the preservation of what has been built on the basis of previous policies and for elaboration of the more recent recovery and inclusion policy ideals into a forceful and directive national implementation plan. At the core of this plan should be, according to interviewees, solid funding of community support, especially flexible, long-term and coherent support in independent living, social contacts, education and employment. This funding should be ring-fenced and structural. In addition, such a community support funding system should be backed up by general funding prerequisites for statutory organizations and by a range of national stimulation and innovation programs. Both general funding prerequisites and national innovation programs should be targeted at local partnership and at local development and implementation of recovery and inclusion policies.

4 The Netherlands - Alkmaar

4.1 The Dutch mental health care system

Compared to the Danish and the English systems - and compared to that of many Western European countries, for that matter - two characteristics are distinctive of the current mental health care system of the Netherlands. The first is the high number of psychiatric beds. The second is the central role of competitive health insurers in mental health care commissioning.

Psychiatric inpatient capacity in 2009 was an estimated 23,000 beds, which comes down to 135 beds per 100,000 inhabitants. This is one of the highest numbers in Europe. Whereas in many countries inpatient care has declined in the past 20 to 40 years, the capacity in the Netherlands has hardly changed in this period. Nonetheless, besides this high and steady inpatient capacity, the number of residential facilities grew at a rapid rate, especially in recent years.

The other distinctive feature of the Dutch mental health system is the result of a major health care reform in 2006. Central to this reform was the introduction of the Health Insurance Act (Zorgverzekeringswet, ZVW). Under this new legislation, consumers are free to choose any health insurer, while health insurers in turn are expected to compete for clients on the basis of their premium rates and the quality of contracted providers. Health insurers are to a large extent free in what providers they purchase services from. From 2008 the Health Insurance Act also applied to the larger part of mental health care.

In the next pages we will go further into the legal and capacity issues of Dutch mental health care. For this moment we would like to point out that the new funding system is expected to have implications for (among others) the geographical organization of mental health care, but that for the time being, a regional structure prevails.

Main mental health care providers

In 2011 by far the largest part of secondary mental health care in the Netherlands is provided by 31 regionally oriented, 'integrated' mental health care organizations. The term 'integrated' stems from the fact that all of these providers originate from regional mergers (mainly in the nineties), of regional psychiatric hospitals, regional community mental health care organizations and often also non-psychiatric regional providers of residential facilities for persons with severe mental health problems. Mergers were voluntary and partly strategic, although national authorities did plea for integration of services. Currently only a few independent psychiatric hospitals and a few independent community mental health care organizations are left. Concerning non-psychiatric residential facilities, approximately half (20) of the providers have stayed independent until

now. As a result, an estimated 85 % of total mental health care 'production', is now provided by the integrated mental health care organizations.

Under the recent health care reform, integrated mental health care organizations are not confined to their region of origin anymore. As said, this has not led yet to large shifts in catchment areas, although actual catchment areas do begin to overlap and some mental health care providers have explicitly formulated an expansive strategy (including sophisticated marketing strategies). Most notably, however, is a new wave of mergers, this time not so much of a regional but an interregional nature: neighboring (but sometimes also distant) integrated mental health care providers have been merging at a rapid pace recently. This has led to a further reduction of the total number of providers, while the average size of providers and of catchment areas continue to rise.

Mental health care services

Obviously, integrated mental health care organizations provide a broad range of mental health care services. To start with, they are the main provider of inpatient facilities²⁴. Part of these facilities is for children and adolescents, for forensic psychiatric care and for specialized drug addiction treatment. Of the total of 23,000 psychiatric beds in the Netherlands, approximately 19,000 are destined for adults, including elderly²⁵. Important to note is that inpatient services in the Netherlands can be divided into three types: general inpatient services for acute admission or time-out; specialized inpatient treatment facilities; and long stay/residential psychiatric facilities. While most inpatients are users of the first two types of inpatient services, the largest part (60%) of psychiatric beds are destined for long-stay/residential care. In the past decade there has been a process of deconcentration of inpatient services to scattered small-scale facilities. However, it is estimated that a majority of inpatient facilities, specifically for long stay care, are still located on the old psychiatric hospital terrains (mostly located in the countryside).

The inpatient facilities mentioned above, all stem from the former psychiatric hospitals that are now part of the integrated mental health care organizations. But as residential facilities are concerned, the former psychiatric hospitals are not the only providers. Non-psychiatric residential care in the form of sheltered housing facilities for persons with mental health problems is also provided through specialized regional residential care providers (of which about half have also been integrated in larger mental health care organizations in the past ten years). As said, the number of these sheltered housing facilities has grown very rapidly in the past years. While this number had already grown from 4,000 places in 1993 to 7,000 in 2004, the total number of non-psychiatric residential

24 A small portion of inpatient care is provided by other organizations, especially psychiatric wards of general hospitals, small specialized providers in niche markets and a few psychiatric hospitals that have stayed independent.

25 No distinction between facilities for working age adults and facilities for elderly can be made on the basis of the national figures.

places has climbed to 14,000 in 2009 (approximately 85 per 100,000 inhabitants)²⁶. Many of these services are group homes with shared living rooms and sanitation. There is a tendency, however, of downsizing and individualizing these facilities.

Also in the field of outpatient services, the integrated mental health care organizations have by far the largest share in 'production'²⁷. A big part of these secondary mental health care outpatient services consists of relatively short term sessions, apparently for persons with less severe or persistent mental health problems (approximately 40 % of the contacts last less than three months, 75 % less than one year). The proportion of outpatient care for adults with severe mental health problems is not exactly clear, but as can be inferred from the above, approximately one quarter of outpatient contacts last more than a year.

In the past 15 years social psychiatry in the Netherlands has gradually transformed into a range of specific outpatient services for persons with severe and long-term mental health care problems. Starting from the nineties and under the influence of a strong national (but now repealed) incentive fund, psychiatric home care services (both acute and long term), supported living arrangements and clinical casemanagement projects emerged. More recently Dutch mental health care witnesses a very strong rise of Assertive Community Treatment (ACT) and a derivative of it, called Flexible ACT (FACT) (Van Veldhuizen, 2007). Essential to ACT and FACT is the broad, integral approach (support is principally provided or organized on all areas needed – from psychological treatment to work assistance), the intensity and duration of the support services (as intensive and as long as necessary), the multidisciplinary staff, the team responsibility for the clients' wellbeing (also in case of hospitalization), the decentralized positioning of the teams in districts and the close cooperation with other local and neighborhood organizations²⁸. It should also be noted that, although ACT and FACT have become strongly embraced, the actual ACT and FACT capacity is still relatively modest. In 2011 approximately 130 teams, not evenly scattered throughout the country, serve 3 % of all annual mental health care clients and an estimated 10-15 % of all adults with severe and long term mental health problems.

As in many countries, services in the fields of participation and social inclusion mainly consist of a range of various small scale projects and facilities. Central to these are the (segregated) day centers of the integrated mental health care organizations. The day centers offer recreational, educational and vocational services. In addition, a range of consumer run organizations are involved in (or have initiated themselves) various projects

26 Total inpatient and residential facilities in the Netherlands would add up to 37,000 or 220 per 100,000 inhabitants.

27 A small portion of outpatient care is provided by other providers, specifically small specialized providers in niche markets, private practicing psychologists and psychiatrists, and a few community mental health providers that have stayed independent.

28 Main difference between ACT and FACT is that the former is tailored to persons who are in need of permanently high intensity care, while the latter is more flexible in intensity and adjusts to changing needs of clients in this respect.

in the field of social contacts, self-help, education and work. In recent years the vocational rehabilitation method of Individual Placement and Support (IPS) is being implemented in several regions (although the total capacity is still low). In addition, efforts are being made (starting from the nineties already) to implement rehabilitation and (more recently) recovery principles in mainstream mental health care. Indications are that progress is made but at a cautious pace. Also notable about the Dutch situation in general is that local authorities (municipalities) have thus far had little interference with mental health care or community support for persons with (severe) mental health problems (except for some scattered initiatives). Where local authorities do interfere, this is mainly confined to leading the most marginalized (homeless) persons with mental health problems into care programs.

Mental health care staff and clients

Mental health care in the Netherlands is staffed by approximately 64,000 fte employed in mental health care organizations. In addition, there are approximately 3,000 private practicing mental health care professionals²⁹. The total capacity comes down to 395 fte per 100,000 inhabitants. Approximately 40-45 % of the staff consists of psychiatric nurses, 30-35 % is medical or other therapeutic staff and the remaining 25-30% is non-client-related staff.

Mental health care organizations served a total of approximately 940,000 clients in 2009. This comes down to more than 5,500 per 100,000 inhabitants. Approximately 90 % only use outpatient services. The total number of mental health care consumers has risen gradually and continuously (outrunning the population's growth) in the past decades and still does.

The exact number of mental health care consumers with severe and long-term mental health problems is hard to depict, also for reasons of definitions and inclusion criteria. Estimates of the total population of adults with severe and persistent mental health problems range from 75,000 to 225,000 (or 500 to 1,500 per 100,000 inhabitants). Indications are that a vast and growing majority of this population are long-term consumers of mental health care.

Financing, funding and expenditures

Total mental health care expenditures in the Netherlands added up to 5.5 billion euro's in 2009. This comes down to 330 euro per inhabitant, more than half of which is spent on inpatient and residential care.

Until 2007 mental health care was largely financed by one national funding system. Since 2008 financing is spread over several sources. The two most important ones are the new Health Insurance Act (Zorgverzekeringswet - ZVW) and the Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ).

29 In overlapping categories: 600 psychiatrists, 1,100 psychotherapists and 1,400 primary care psychologists.

As said, the Health Insurance Act was introduced in 2006 in curative somatic health care and in 2008 in *mental* health care. The Health Insurance Act is an obligatory national health insurance system, executed by independent health care insurers. It might be viewed as the main instrument in a market oriented health care transformation process in the Netherlands, as the Act is aimed at making room for competition between insurers and between health care providers (health insurers competing for clients and health care providers competing for contracts with insurers; see paragraph 4.2). The Health Insurance Act covers all essential curative health care. Regarding mental health care, the Health Insurance Act covers nearly all out-patient care and all short term (less than one year) inpatient care. The Health Insurance Act accounts for nearly two thirds of mental health care funding.

The second funding system is the Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten - AWBZ). The AWBZ covers inpatient and outpatient care for older people, people with disabilities and, until recently, most of the care for people with mental health problems. The AWBZ was introduced in 1968 already, with the intention of establishing a solid social insurance for the care for people with more severe or chronic health problems or disabilities. Regional AWBZ offices (formally non-competitive but since 2008 managed by independent insurers) are the administrators of the AWBZ. Regarding mental health care, the AWBZ since 2008 broadly covers all long term inpatient care (more than one year), all non-psychiatric residential care (sheltered and supported housing facilities) and day centers. The AWBZ accounts for approximately one third of mental health care funding.

Of the several other and much smaller funding resources of mental health care, one needs special mentioning. That is the Social Support Act (Wet Maatschappelijke Ondersteuning - WMO). The WMO is aimed at the general population and covers a broad range of social care domains, such as household support, youth centers, sheltered accommodation and special transportation facilities for people with physical disabilities. The WMO was introduced in 2007, one year after the implementation of the new health insurance legislation. In this new WMO system, several previous social care laws have been brought together. Under the WMO, local authorities are the administrators of budgets and have considerable autonomy in deciding how to spend these (budgets in the WMO are not earmarked and - as opposed to the ZVW and the AWBZ - there are no individual entitlements). It is estimated that only 1 or 2 percent of total expenditures of mental health care organizations is funded through the WMO. Estimates on WMO-expenditures on other services for persons with mental health problems are also low (and mainly restricted to the funding of local consumer organizations, for which a specific AWBZ-fund was transferred to the WMO).

The importance of the WMO is not so much in its current expenditures on services for persons with mental health problems, but in the fact that the act specifically states that local authorities should make efforts in social inclusion of persons with long term mental

health problems. In this sense the WMO is a standard, recurrent item when community support is addressed in Dutch national policy documents. Moreover, plans have been made for a further decentralization of responsibilities from the AWBZ to the WMO. Especially AWBZ-entitlements for services in the field of social support (supported housing) and day activities (day centers) will end in 2013. Plans are that these will be replaced by general WMO-services of the local authorities.

To summarize, the Dutch mental health care system can be characterized by its relatively extensive inpatient and residential facilities and by its transformation from a relatively clear-cut, non-competitive regionally organized sector into a multi-budget, more competitive system, increasingly directed by independent health insurers.

4.2 Dutch national policy on mental health care and community support

National policies on mental health care and community support for persons with severe mental health problems in the Netherlands, can be divided into three stages. Characteristics of these stages are an initial emphasis on promoting community care, followed by a shift of focus towards the introduction of market incentives and very recently followed again by a renewed attention for the possibilities of downsizing high inpatient capacity.

In the last decade of the previous century, national mental health care policy was characterized by explicit pleas for the development of good quality community care and for an emphasis on developing opportunities for social participation of persons with severe mental health problems. Policy measures concentrated not so much on enforcement of these objectives, however, but on incentivizing good practices through incentive funds. As mentioned in the previous paragraph, these measures did promote the development of several specialized outpatient services for persons with severe mental health problems. It also promoted the emergence - in a cautious pace - of a rehabilitation perspective and of several consumer run initiatives. It did not result, however, in the extensive deinstitutionalization process, as witnessed in many other countries. Inpatient capacity did decline but only very modestly.

Around 2002 a turn took place in national mental health care policy. From that time on policy attention became strongly focused on the implementation of a more market oriented health care system. Competing health care insurers, purchasing services from competing health care providers, were designated as the future driving forces behind cost containment and quality improvement. The preparation and implementation of the Health Insurance Act as the crucial tool in this process became the central policy issue. In this process mental health care as such was not a separate policy domain. Mental health care policy in fact was a derivative of general health care policy and of general

health care transformation objectives. More specifically, the transfer of the largest part of mental health care funding to the disorder related reimbursement system of the Health Insurance Act became the central mental health care policy issue. Also, crucial policy documents proclaimed that long term care should no longer be the central focus of mental health care policy, as by far the most clients were short-term consumers.

In actual practice, the new, more 'liberal' character of mental health care policy from 2002 went together with reduced attention for long-term community care, a renewed (slow but persistent) growth of inpatient facilities and an acceleration of the growth of mental health care residential facilities. Also in this period, policy plans were developed for the decentralization of social support services from the mental health care funding system of the AWBZ to local authorities and to the new Social Support Act (WMO). As was outlined in the previous paragraph, some reductions in AWBZ-entitlements have in the meantime taken place and further actions currently are in preparation.

The third stage in mental health policy of the past decades has in fact just begun and was preceded by some small-scale stimulation projects, resuming attention for community care and community support for persons with severe mental health problems. One of these stimulation projects was called 'Recovery and citizenship' (*Herstel en burgerschap*), financed by the Ministry of Health care and aimed at exchanging ideas and experiences concerning social inclusion of persons with severe mental health problems. Main participants of the project were national representative organizations of mental health care providers, social care providers, institutions in the field of employment, local authorities and consumers. Another program initiated by the Ministry of Health care was the Transition Program Long-term Care, that granted temporary subsidies for local innovations in long term community care (not only mental health care). Both programs ended in 2011. However, in the meantime, the deinstitutionalization debate has been forcefully revitalized by health insurers. While independent health insurance companies have taken up their role in mental health care since 2008, substantive involvement in mental health care provision was relatively modest and explorative at first. Lately however, the relatively high levels (and costs) of psychiatric inpatient capacity have caught the attention of the insurers. In their yearly negotiation cycles with mental health care providers about next year's contracts, health care insurers have begun formulating targets for downsizing inpatient capacity³⁰. Meanwhile, national authorities have now also adopted the reduction of the number of psychiatric beds as an explicit policy objective. Recently, policy measures have been taken to facilitate the transfer of budgets from inpatient to outpatient care.³¹

30 Health care insurers' influence in this respect is strengthened by the fact that only four independent insurers control almost 90 % of the health insurance market. In addition, as the clients of these insurers are not evenly distributed over the country, in most regions one of these four companies controls more than 50 % of the insurance market.

31 Good quality community care has also become an important aspect in the development of national guidelines for services for persons with severe mental health problems (Van Weeghel et al., 2011). The development of these guidelines is stimulated by the national authorities but implementation is not enforced.

In conclusion, it can be stated that community support for persons with severe mental health problems as such has not (yet) developed into a major national policy objective in the Netherlands, although bed reduction objectives have regained support lately. At the same time, policy and funding system transformations have taken place that greatly affect the circumstances for ongoing local initiatives and efforts to develop community support services and favorable social inclusion conditions. Currently adding to that are mental health care budget cuts, the introduction of obligatory partial out-of-pocket payments in mental health care and also developments in social care, specifically changes in the benefit system, leading to stricter obligations to accept paid or unpaid employment.

In paragraph 4.4 the judgments of the consulted experts and key persons on the impact of past and current policies and system characteristics on the development of community support for persons with severe mental health problems in the Netherlands, will be discussed. Before we get to that, we present an overview of mental health care and community support services in the region of Alkmaar.

4.3 Characteristics and community support facilities of the Alkmaar region

The Dutch region that we will focus on in our study consists of the city of Alkmaar and its surrounding rural area. The region is known under the name of North-Holland North (Noord-Holland Noord). It covers 1,057 km² and in 2011 counts over 435,000 inhabitants (411 per km²) of whom almost 100,000 are inhabitants of the municipality of Alkmaar³². The average education level of the region's population is relatively low compared to national average.

In our study, when we speak of Alkmaar, we are referring to the region of North-Holland North, unless stated otherwise.

Mental health care in the Alkmaar region

The principal provider of specialized mental health care in Alkmaar is Geestelijke Gezondheidszorg Noord-Holland Noord (GGZ NHN - Mental health care organization North-Holland North). An estimated 85 % of mental health care in this region is provided by GGZ NHN³³.

GGZ NHN is an integrated mental health care organization that provides a broad range of inpatient and outpatient services for several categories of clients. Until 2009, the catchment area for GGZ NHN coincided with the region mentioned above. After a

32 Sizes of age groups are: 100,500 (23 %) <19 years, 269,600 (62 %) 19-64 years and 65,200 (15 %) > 64 years.

33 Other providers are two specialized mental health care organizations for children/youth and for geriatric services and private practicing psychiatrists and psychotherapists.

merger in 2009, a neighboring region was included. The focus in this report will be restricted, however, to the capacity and services of GGZ NHN in the original catchment area of North-Holland North.

Services of GGZ NHN are organized in four divisions, being 'short term psychiatry', 'department of severe mental illness', 'care for the older adults' and 'forensic treatment'. In addition, the organization has a specialized treatment center for people with autism. GGZ NHN services are provided in more than 30 locations in the region. The staff of GGZ NHN consists of approximately 1,400 employees or a little more than 1,000 fte³⁴, of whom approximately 40 % are psychiatric nurses. Revenues in 2008 were 82 million euro (less than 200 euro per capita of the catchment area)³⁵.

At the end of 2008 GGZ NHN counted over 7,600 clients (which comes down to a point prevalence of almost 1800 per 100.000 inhabitants). Approximately 90 % of these clients were working age adults. Approximately 20 % were clients of the department of severe mental illness (1,400 persons; 320 per 100,000 inhabitants).

Inpatient and residential care

GGZ NHN is known for its relatively low inpatient and residential capacity compared to other regions in the Netherlands. In 2010 GGZ NHN counted 322 psychiatric beds. This comes down to 74 beds per 100,000 inhabitants, a little over half of the average inpatient capacity in the Netherlands. Approximately half (157) of the psychiatric beds of GGZ NHN are destined for acute inpatient care and the other half (165 beds) for long stay care. GGZ NHN also provides sheltered housing facilities (inherited from an earlier merger with a regional provider of non-psychiatric residential facilities for persons with long-term mental health problems). The total number of sheltered housing places of GGZ NHN was 136 in 2010. This comes down to 31 places per 100,000 inhabitants, which is less than half of the national average³⁶.

Sheltered housing facilities are available in a variety of sizes, housing specifications and care intensity. They also are the home base for supported housing to persons with severe mental health problems living in the direct vicinity (often persons who have moved from sheltered housing to independent living). Cooperation in the field of supported housing has developed with the regular home care organization Actiezorg, that offers specialized home care to some of GGZ NHN's clients.

A general tendency in housing of persons with severe mental health problems in NHN is a transfer from group homes to more individual (clustered) apartments. Also a relatively

34 This comes down to a little less than 250 fte per 100,000 inhabitants of the catchment area.

35 Main funds were 50 % ZVW (the new Health Insurance Act), 35 % AWBZ, 14.5 % Ministry of Justice (forensic care) and 0.5 % WMO (local authorities).

36 Not counted in figures of the GGZ NHN inpatient and residential capacity are 32 forensic beds, 12 forensic sheltered housing places and an estimated 164 places for day treatment.

recent development is GGZ NHN hiring housing accommodations from regular housing corporations and renting these accommodations to GGZ NHN clients. Through this construction clients can get priority access to regular housing. After a specific period of time and if the client has proved capable, the contract is transferred to a regular tenant's contract between the client and the housing corporation. In 2010 accommodations were rented with this construction to 73 clients on 46 locations, mostly consisting of detached and sometimes clustered residences.

Outpatient care: FACT

GGZ NHN is also recognized as an advocate of the development of community care for persons with severe mental health problems and as a frontrunner in the implementation of the method of FACT (Flexible Assertive Community Treatment). As described in paragraph 4.1, FACT-teams are characterized by their integral, multidisciplinary, flexible, district based approach. The FACT-teams support their clients on a broad terrain, from housing, work, education and day activities to social contacts and family life as well as psychiatric treatment. The content and intensity of contacts are arranged according to the actual situation. The intensity can be upgraded to four or five contacts per day if necessary. In case of hospital admission, the coordination of care remains with the team.

GGZ NHN counts nine FACT-teams, each working for a specific geographical area. The total FACT-formation is 97 fte in 2011. These nine teams serve 1,200 clients. Compared to other regions FACT-capacity and scope (in terms of number of clients reached) is a threefold of national averages. It might be presumed that also social psychiatric capacity as such (regardless of specific methodical and organizational structures) is higher than the national average in the region of Alkmaar, but no figures are available to conclude definitely on that.

Community support services in the Alkmaar region

In addition to the services mentioned above, GGZ NHN is involved in a range of community support services in the field of day time activities, social contacts, education and vocational rehabilitation. A pivotal role in these services is played by the five activity centers of GGZ NHN itself. In these activity centers, a total staff of 69 fte serves approximately 1,150 clients (point prevalence; almost all clients also receive support from the FACT-teams). The activity centers offer services in the fields of creative, recreational, educational and vocational activities. These services consist of sheltered activities at the centers themselves but also support programs in (finding) regular education or work elsewhere.

In the past years GGZ NHN has started employing clients in (partly paid) jobs in its own administrative, catering, transport and maintenance services. The management of these services has been integrated in the management of the day centers. In addition, GGZ NHN offers vocational rehabilitation services through the method of Individual Placement and Support (IPS), since 2008. Nine IPS workers of the regional (non-categorical) organization for sheltered work and job coaching are detached at the FACT-teams of

GGZ NHN. This construction is said to be unique for the Netherlands as is the relatively high IPS - capacity in the region. In 2010 approximately 250 clients were in an IPS-program. In 2009 and 2010 a total of 45 clients attained a paid job through IPS.

Part of the region's community support services for persons with severe mental health problems is provided by other organizations - although often in attunement with GGZ NHN workers. In the field of social contacts and day activities for instance, some GGZ NHN clients make use of welfare organizations' buddy projects and regular community centers. Concerning education and work, a few clients are students of the regular regional education center; others are employed at the regular regional organization for sheltered work. In all cases GGZ NHN (FACT-) workers are in contact with the respective organizations concerning adequate support to these clients.

Recovery and consumer-run activities

The Strength Model has been adopted as GGZ NHN's guiding approach in service delivery to persons with severe mental health problems. In addition, GGZ NHN has set up several activities to develop a recovery-orientation among its clients and employees. Recovery oriented treatment plans have been introduced, consumer groups discussing recovery and social participation have been initiated and approximately twenty workers with long term consumer-experience in mental health care have been employed in the FACT-teams and day centers. Recently the nationally operating consumer-run TREE—project (the Team for Recovery, Empowerment an Experiential knowledge) has been invited to run their training and development programs with clients and with professionals in the organization.

Also involved in consumer-run activities and in the development of a recovery approach in NHN is the Regional Client Organization (RCO) de Hoofdzaak. De Hoofdzaak houses several consumer-run projects and self-help-groups. It provides training in recovery and experiential knowledge for regional long term mental health care consumers. Next to that it offers a range of services, from education and courses to a social participation helpdesk. Approximately 70 % of the employees of De Hoofdzaak have consumer experience in mental health care.

Cooperation and coordination

As can be inferred from the above, GGZ NHN invests a lot in community networking and cooperation. A leading principle is a focus on the (the development of) individual social networks, in line with individual wishes and aspirations. The Fact-teams play a central role in this. Fact-workers are educated in networking. On the basis of their clients' needs and wishes Fact-teams actively try to connect to neighborhood facilities.

But investments are also made in networking and community cooperation on an aggregated level. GGZ NHN enables some employees to actively perform as community development workers. Cooperation between GGZ NHN and regular home care, housing corporations and vocational organizations has already been mentioned. Another

example is the organization of mutual consultation concerning individual casuistry in the region in so-called network tables. These are regular meetings of workers of several organizations, discussing each others' potential roles in supporting individual clients in realizing their wishes concerning social activities.

A very important partner of GGZ NHN when it comes to the development of community care and community support is the health insurance company UVIT. This company has clients throughout the country but has by far the largest market share in NHN. It is therefore the most important negotiating partner for GGZ NHN when it comes to ZVW-funding of outpatient and acute inpatient care. It is also the regional administrator of the AWBZ's long stay care. Special about the cooperation, compared to general practice in the Netherlands, is that it is not restricted to standard yearly production contracts but that the insurance company tries to put more than average efforts in facilitating the development of community support. It does so through, for instance, the transfer of funds from long-stay care to the FACT-teams, and, in cooperation with GGZ NHN, through initiatives to make long-term plans and to actively involve other stakeholders (for instance local authorities) in the development of a coherent and comprehensive community support system for persons with severe mental health problems.

In 2009, GGZ NHN has taken the initiative to lift the regional cooperation in the field of community support to a more structural level through the establishment of the Regional Transition Group (Regionale Werkgroep Transitie NHN). The aim of the project is to generate a coherent, comprehensive and solid regional interagency organization of mental health care and community support services, with strong commitment from all relevant stakeholders (also on an administrative level) and with FACT as its central and widely accepted core. Among others, the dominant regional health insurer and funding company UVIT, local authorities, regional organizations in the fields of public health care, employment and disability benefit schemes (the same organizations financing regular workplace reintegration programs), sheltered work, employers organizations and the local consumer organizations, were invited to participate in the Regional Transition Group. Current indications are that the formation of the Regional Transition Group has not yet led to the intended comprehensive and well-coordinated interagency venture but did have positive effects on the involvement of other local stakeholders (see also the next paragraph). A complicating matter for the further development of the initiative is that funding from the Transition Program Long Term Care ended in 2011.

To summarize, from a national perspective the Alkmaar region is a somewhat atypical region regarding mental health care and community support services for persons with severe mental health problems. It has, compared to national averages, a relatively low inpatient and residential capacity. And its main mental health care provider, GGZ NHN, has very explicitly (and already long ago) adopted community care in the form of FACT as the core of its long term care services. For these reasons GGZ NHN is considered a frontrunner in community care in the Netherlands. GGZ NHN is also making efforts to

lift the attention for community support and social inclusion to the level of a widely recognized common cause, involving all relevant local stakeholders.

4.4 Regional key persons' perspectives on incentives for community support

Perspectives on the achievements, eventual shortcomings and future challenges of the local community support system in Alkmaar were further examined and discussed in a series of individual and group interviews with approximately twenty key persons in the local community support network (see appendix). Interviewees represented a broad range of relevant (professional and client) organizations and services in the domains of mental health home care, housing, participation (education and work), recovery and coordination and planning. Next to the local situation, specific focus in the interviews was on the incentives and disincentives of the national policy and mental health care system on the development of community support and social inclusion.

Community support achievements in Alkmaar

According to key persons GGZ NHN has a long tradition in rehabilitation and participation of persons with severe mental health problems and in innovations in community care and community support. The organization has often been successful in getting national grants for innovation projects. One of the main achievements of the past decade is that this tradition has evolved into a well thought out and documented policy and organization of services. As in the other countries and regions involved in this study, no representative data are available (yet) on the actual impact of these developments and services on the quality of life of consumers in Alkmaar. But impressions of key persons are positive in general. Especially important, according to interviewees, has been the introduction of the decentralized, neighborhood-oriented and at the same time comprehensive FACT-teams, aiming at integrated support across all life domains (psychiatric symptoms, independent living, social contacts, work etc.). The Fact-teams are believed to provide for a solid community care and community support structure. Next to that, continuous networking on all levels has resulted in many important and successful formal and informal partnerships. Moreover interviewees believe that recovery - once considered an interesting but minor novelty - is now beginning to get a foothold as an important change in perspectives and modes of interaction between consumers and professionals.

As mentioned earlier, because of the initiatives and innovations mentioned above, GGZ NHN is considered a frontrunner in community care and community support in the Netherlands (it has been awarded for its care innovations). Key persons point to the fact that two favorable conditions contribute to this position. The first is the fact that the board of GGZ NHN not only strongly supports the developments towards community support and social inclusion, but is also prepared to take risks to this end. Especially the downsizing of inpatient capacity, to make room for outpatient innovations, is consid-

ered a risky venture from a business economic point of view (inpatient care is a stable source of income and adequate funding of outpatient alternatives is not guaranteed). A second favorable condition is that the dominant regional health care insurer (the main purchaser of ZVW-funded mental health care and also regional administrator of the AWBZ's long term care) fully backs GGZ NHN's vision and efforts. Both organizations share the conviction that ultimately costs of care will be lower and general social and economic benefits will be higher in an adequate community support system (as opposed to a predominantly clinical system). A joint social and economic business plan of the FACT-structure has been set up, that underpins this conviction. Based on this common vision, both organizations are also believed to share a sense of mutual trust, which offers room for further innovations and experiments.

For the near future, a central issue in the plans of GGZ NHN and the regional health insurer is securing the current FACT-structure by ways of an integral funding system. In actual practice FACT is currently funded from the ZVW and the AWBZ. However, FACT-teams also perform social support and vocational activities that formally do not belong to the health care domain of the ZVW or the long-term care domain of the AWBZ but to that of, for instance, the social support domain of the WMO or vocational domain of regular reintegration funding systems. National policy plans to transfer responsibilities from the AWBZ to local authorities and to the WMO, will increase the urgency to arrange adequate integral funding for the FACT-teams.³⁷ This means that involvement of local authorities is becoming crucial, not only for regular social support services, but also for the funding of FACT. The possibility of a joint community care and community support purchasing agency, installed by local authorities and health insurers, is being explored.

As the further development of community care and community support is concerned, several new plans have been launched. These plans are, among others, about the development of 7 X 24 hours FACT, the implementation of digital and internet applications for continuous accessibility and for social participation, and the further implementation of the recovery approach. In general, and concerning the more distant future, ideas are in progress to continue deinstitutionalization, develop joint habitation with regular services and transfer activities to these services.

Positive community support incentives from the national policy and system level

Throughout the years the development of community support in NHN has benefitted from several national innovation programs. In the years around 2000, the temporary *Care Innovation fund (Zorgvernieuwingsfonds)* allowed for a transfer of budgets from clinical care to intensive outpatient alternatives. Lately, GGZ NHN has profited from the *Transition Program Long-term Care* (see also paragraph 4.2). Many of the projects

³⁷ Efforts in this field are also taking place on a national level, where a partnership of providers and researchers is calculating how an integral FACT-budget should be composed from the several relevant funding systems.

and initiatives mentioned above have been financed by this innovation program, for instance the development of IPS, the introduction of network tables, the installation of the Regional Transition Group and the social and economic business case for the FACT-model. Key persons also mention the nationally funded exchange and development program *Recovery and Citizenship (Herstel en Burgerschap)* as a project that stimulated the development of services and of a community support system in NHN.

Next to NHN and to different degrees, other regions and organizations have also benefitted from these national innovation programs. Especially the earlier *Care Innovation fund* is believed to have had substantial and positive impact (as it dealt with a substantial amount of money), not only on the development of outpatient care but also on consumer initiatives. The *Care Innovation fund* ended halfway the previous decade however. The *Transition Program Long-term Care* was much more modest in impact. It was not aimed at facilitating permanent budget transfers to innovative care, but at subsidizing temporary projects. Moreover, the *Transition Program* ended in 2011 as has the exchange project *Recovery and Citizenship*.

According to interviewees, and besides the programs mentioned above, the overall contribution of national policy and system characteristics to the development of community support for persons with severe mental health problems in the Netherlands and in NHN in the past decade, has been very modest. (In some respects, as will be illustrated in the next pages, national policy has in fact been experienced as a disincentive.) Interviewees also affirm that in their opinion community support and social inclusion have not been very prominent national policy issues. Moreover, perceptions of the latest, renewed attention for psychiatric bed reduction are ambivalent. In principle this development offers new chances for adequate community alternatives, but there are doubts as to whether inpatient budgets will in fact be reinvested in outpatient care.

A similar ambivalence can be traced concerning the current transfers of responsibilities from the AWBZ (the national funding system for long-term care) to the WMO (the social support funding system, controlled by local authorities). Some interviewees believe that for instance the expected consequential closure of categorical day centers can serve de-stigmatization. They also believe that the WMO offers new funding opportunities for services to persons with severe mental health problems, not as psychiatric patients, but as citizens (be it sometimes vulnerable citizens). Upcoming changes in the benefit system, leading to stricter obligations to accept paid or unpaid employment, are also expected by some interviewees to lead to a positive change in perspective from disabilities to capabilities.

The ambivalence concerning these measures, as sensed by many interviewees, is again that neither the decentralized, competitive health care system, nor the non-ring-fenced social support funding system of the WMO, offer guarantees that alternatives will actually be developed for the services that are being broken down.

Barriers and future challenges in community support in Alkmaar

Turning back to Alkmaar, the interview results suggest that the region has a relatively solid basis from which to proceed in the development of a community support system for persons with severe mental health problems. However, interviewees also point at some important challenges that will have to be taken on at a regional as well as at a national policy level. Starting at the regional level, main challenges are believed to be in mental health care culture on the one hand and in the involvement of local authorities on the other.

According to key persons the enforcement of a definitive breakthrough is still needed in the traditionally predominant psychiatric and sometimes paternalistic culture of the regional mental health care provider. Some key persons even believe that stigma is still the strongest in mental health care itself. Interviewees indicate that recovery is high on the policy agenda of GGZ NHN but that in daily practice and daily interactions professionals and clients often still take on their traditional roles. "In all they say and do, people feel that they are patients, like prisoners in a striped suit." Some also warn for a professional colonization of the recovery-concept, turning recovery into a new professional method in an old culture. Others even point at an inherent risk of mental health care's integral and 'assertive' FACT-model turning into an all-embracing, paternalistic, psychiatric service. In general, interviewees believe that it is important to assure that at all levels persons with severe mental health problems are no longer addressed (and no longer address themselves and each other) in their client role, but in their regular social roles, focusing on what is needed to fulfill these roles.

Involvement of local authorities in supporting persons with severe mental health problems is considered to be another main challenge for the near future. Local authorities so far have had little specific interference with this population. They do play an important role, however, in regular service provision in the fields of housing, welfare, benefits and work. They can therefore make a potentially substantial contribution to the social inclusion of persons with severe mental health problems. Moreover, their position will become increasingly important as a consequence of the transfer of responsibilities from the health care system (AWBZ) to the WMO (Social Support Act), of which local authorities are the budget-holders.

Regional experiences in NHN so far are not unequivocally hopeful, however. Key persons assert that it is difficult to get local authorities' attention for the population of persons with severe mental health problems. As the WMO is concerned (and as opposed to the health care funding systems) budgets are not ring-fenced and there are no individual entitlements. Local authorities have considerable autonomy in deciding how to spend their budgets. Persons with severe mental health problems are a relatively small group compared to other WMO target populations like elderly and persons with physical handicaps. Success is dependent on the casual interest of a local council-member and is hard to secure in long-term agreements. Also involvement is needed of several local

departments (welfare, benefits, reintegration, public health) , each with their own vision and approach. Especially the fragmented field of welfare (many temporary subsidy-based projects) is considered a difficult domain to establish structural agreements and services continuity. Moreover, the region counts tens of municipalities. From the perspective of GGZ NHN investments in cooperation with all of these municipalities is impossible but also cooperation with the largest ones is very time-consuming, especially compared to potential financial revenues.

Next to mental health care culture and the involvement of local authorities, recent or announced budget cuts in public services are turning into new regional barriers or challenges, according to key persons. It is becoming more difficult to receive grants for extra support, organizations tend to retreat to their core businesses and some services that are crucial for social inclusion (for instance community centers) are at risk of being closed.

Disincentives and barriers to community support from the national policy and system level

Many of the regional barriers and challenges mentioned above are linked to national policy, especially the complexities of local authorities' involvement and the current budget cuts in public expenditures. But interviewees also explicitly mention a few additional barriers to social inclusion on a national policy and system level. At the core of the comments of key persons on the Dutch national policy, concerning services for persons with severe mental health problems, are the segmented silo-financing in mental health care and community support, some perverse incentives of the current imbursement systems, a hazardous overvaluation of the merits of market competition and the absence of a comprehensive social inclusion policy.

The organization of comprehensive and coherent support for persons with severe mental health problems is hindered by the fact that these support services are dependent on a range of funding systems, each with its own procedures and each with a tendency of responsible agencies to restrict access and refer to other funds. Mental health care alone is funded through four systems. When housing or vocational services come into play, matters become even more complicated. This situation makes it very hard for clients to get access to the right services at the right time. It also very much complicates funding of integral services as FACT. In current practice funding of coherent and comprehensive support is to a large extent dependent on local improvisation and the willingness of relevant local parties to invest in temporary solutions for funding problems. Where this willingness exists the divergent geographical organization of the several systems poses a next challenge. Health insurers do not have clear catchment area boundaries and also the catchment areas of mental health care providers are not as fixed as they used to be. In NHN the mental health care provider and health insurer managed to find each other, but this is not common practice. To add to that, local authorities and agencies in employment support also all have their own geographical domains, which makes generating the willingness of reaching joint agreements a difficult venture.

Key persons point to the fact that this fragmentation of funding systems is mirrored in the diffusion of responsibilities on national authority level, where the Ministry of health care, the Ministry of social care and employment, the Ministry of justice and the Ministry of housing play key roles. Also within the Ministry of health care itself, separate departments are responsible for ZVW-, AWBZ- and WMO-funded (mental health) services respectively. In absence of a key problems owner of community support and social inclusion of persons with severe mental health problems, the development of a comprehensive social inclusion policy lacks behind, some incidental innovation programs left aside. No community support or social inclusion services are enforced from the national level, which leads to a high level of permissiveness and to relatively large interregional difference in community care and community support capacity and service levels. Also, national policy is said to lack clear choices, leading to some new developments without fundamental changes in the old, relatively strongly institutionalized mental health care system.

Characteristic for this situation are the incentives in the mental health care funding system that still promote inpatient care. No ceiling has so far been determined for inpatient capacity (nor a minimum for community care for that matter). For mental health providers, inpatient capacity still is a solid income base, especially in times of economic pressure. As was shown in paragraph 4.1 clinical capacity did not decline but even grew somewhat in the past decade. Mental health care's residential facilities doubled in this period. Meanwhile, providers that choose to deinstitutionalize cannot do so without taking financial risks. More so because downsized inpatient capacity by one provider can be built up again by another.

Some interviewees point to the fact that adverse incentives are also present in mental health care's reimbursement systems and entitlement criteria. These systems and criteria are predominantly based on psychiatric impairments instead of participatory aspirations and support needs. At the same time administrative procedures for the funding of support trajectories in the field of day activities, education and employment are experienced as extremely time-consuming. Moreover, these administrative procedures have to be followed for each individual trajectory. Individual needs assessments and exploring preferences are not financed at all (GGZ NHN has managed to make a unique but temporary deal on this with the health insurer). And while persons with severe mental health problems often need long-term vocational support, funding for support trajectories themselves is limited in time and frequency. Also benefit traps are said to be a discouraging factor as "the system does not reward people who try and perhaps grow as they take courageous steps, but instead is built for people who theoretically have the best chances". In general the system, and especially the upcoming new benefit legislation is believed to be incompatible with the model fidelity of IPS.

Finally, key persons notice that national policy is characterized by a strong faith in the merits of market competition. Responsibilities are decentralized to the market system of competing insurers and providers and to local politics. Interviewees do not fear this

decentralization and competition as such, but do warn for adverse effects in the absence of adequate incentives and a clear policy vision on social inclusion of persons with severe mental health problems at the level of the system administrator (i.e. the national authorities). Without this vision and these incentives, competitive relationships will only further complicate essential cooperation and coordination on an individual, local and national level. Local politics as well as market competition in health care might then also lead to a shift of attention away from vulnerable clients and citizens towards financially and politically more profitable populations.

Suggestions for national measures to facilitate and promote community support

Key persons have made a range of suggestions for national measures that could remove current barriers and facilitate and promote the further development of community support. These suggestions can be summarized into four categories:

Framework

It is suggested that a national framework should be made, that describes a region's maximum capacity of inpatient and residential facilities and the region's minimum capacity of outpatient and community support services (for instance FACT and IPS). These capacity calculations can be used for regional mental health care and community support budgeting. They can also prevent that the largest parts of mental health care budgets go into non-inclusive inpatient and residential services.

Solid funding of participatory support services

Funding of support in the field of social contacts, day activities, education and employment should be made much less complex and less permissive. Structural funding and clear entitlement should be created. For instance for long-term individual support in employment i.e. for IPS. But also in the WMO, the Social Support Act with its central role for local authorities and local politics. Interviewees suggest that the WMO-budget should be linked to performance measures and that parts of the budgets should be ring-fenced for persons with severe mental health problems. The WMO should be made into an instrument that obligates local authorities to effectively take responsibility for the local community support system for persons with severe mental health problems. It is also suggested that entitlements should be created in the WMO for long-term individual social support. Some interviewees promote the installation of individual recovery coaches: preferably well-educated professionals with consumer experience.

Integral funding

Other interviewees suggest that possibilities should be explored to create integral budgets for the support of persons with severe mental health problems across sectors and funding systems. Such an integral, cross-sector budget could enhance coherence, efficiency and continuity in support services, reduce bureaucracy and counter perverse incentives (shoving off responsibilities). Criteria for integral funding should be made explicit in

terms of clients characteristics and needs and in terms of requirements of the budget-holder. Budgets could for instance be linked to a formal coordinating responsibility. In case of a need for intensive, integral care, the coordinating role and the budget could be assigned to an integral team (FACT). In other cases the budget could be assigned to the organization or professional that is closest involved in daily support of the individual client (primary care professional, recovery coach) or to the client system itself. In all instances the use of the budgets across life domains should be free according to needs.

A comprehensive policy plan

According to many interviewees, national government should formulate one clear and consistent, cross-sectoral plan for community support and social inclusion of persons with severe mental health problems. The plan should include measures to create an inclusive climate, an adequate system of entitlements to support services, clarity about (coordinating) responsibilities on an individual, local and national level and effective financial incentives in all sectors to cooperate in and contribute to the social inclusion of persons with severe mental health problems.

4.5 Main findings

This chapter showed that the Netherlands belong to the European countries with the largest psychiatric inpatient and residential capacity. Recent trends indicate a modest but still continuing increase in inpatient capacity and an accelerating growth of residential (sheltered housing) capacity. Mental health is mainly provided by 31 integrated mental health care organizations.

Despite the high inpatient and residential capacity, community care for persons with severe mental health problems is available in the Netherlands, mostly consisting of regular social psychiatric services of the integrated mental health organizations. Additional services in the fields of participation and social inclusion mainly consist of a range of various small scale projects and facilities of mental health care organizations, consumer organizations, and sometimes partners in social care or sheltered or supported employment.

Community support and social inclusion have not been major issues on a national policy level in the past decade in the Netherlands. Attention was concentrated on the introduction of market incentives, as means for cost containment and quality improvement in health care in general. As a result, since 2008, commercial insurance companies have a central role in mental health care commissioning under the Health Insurance Act (ZVW), which covers approximately two thirds of mental health care expenditures. Health insurers also are the administrators of the Special Medical Expenses Act (AWBZ), covering the largest part of the rest of mental health care expenditures, especially long-stay and residential care.

Central to the latest developments in the Netherlands is a growing interest in the possibilities of downsizing inpatient capacity. More specifically, health insurers have noticed the relatively high inpatient capacity of the Netherlands and have begun formulating targets for downsizing inpatient capacity in their yearly negotiation cycles with mental health care providers about next year's contracts. Meanwhile, on the national policy level, a trajectory has been launched to decentralize responsibilities from the long-term care funding system of the AWBZ to the Social Support Act (WMO). The WMO is administered by local authorities and covers a broad (non-ring-fenced) range of social services for a wider population. Especially AWBZ-services in the field of social support (supported housing) and day-activities are being transferred.

The region of Alkmaar is a somewhat atypical region regarding mental health care and community support services for persons with severe mental health problems in the Netherlands. It has, compared to national averages, a relatively low inpatient and residential capacity. And its main mental health care provider, GGZ Noord-Holland Noord has very explicitly adopted community care in the form of FACT as the core of its long-term care services. FACT-teams are characterized by their broad, integral, multidisciplinary, flexible, neighborhood-based services. GGZ NHN has also adopted a recovery-approach (although key persons indicate that a definitive breakthrough in traditional psychiatric mental health care culture still has to take place). Next to that GGZ NHN is making more than average efforts to lift the attention for community support and social inclusion in the region to the level of a widely recognized common cause, involving all relevant local stakeholders. Crucial to these efforts and relatively unique from a national perspective is the backing from the dominant health insurer in the region, that permits inpatient savings to be invested in outpatient care and assists in trying to involve other funding agencies (local authorities) and stakeholders in the development of an adequate regional community support system.

Throughout the years the development of community care and community support in NHN has benefitted from several national innovation programs. However, according to interviewees, the overall contribution of national policy and system characteristics to the development of community support for persons with severe mental health problems in the Netherlands and in NHN in the past decade, has been modest. In some respects national policy has in fact been a barrier. The following aspects are at the core of the comments of key persons about the Dutch national policy and system characteristics:

- The fragmented silo-financing in mental health care and community support, making it hard for clients to get access to the right services at the right time and complicating funding of integral services as FACT;
- The related diffusion of responsibilities on a local and national level and the consequential absence of a key problem owner and coordinated local or national planning;
- The positive incentives for excluding mental health care services (revenues on inpatient care, psychiatric impairment based reimbursements systems) and the related economic risks for organizations that try to obtain inclusive policies;

- Extremely time consuming administrative procedures for the funding of individual support trajectories in the field of day activities, education and employment;
- Adverse effect of market competition on cooperation and coordination and on investments in vulnerable populations, especially in the absence of a comprehensive social inclusion policy and social inclusion incentives.

In this context the renewed attention on a national policy level for psychiatric bed reduction and the transfer of responsibilities to local authorities is received with ambivalence: neither the decentralized, competitive health care funding system nor the non-ring-fenced social support funding system of the WMO, offer guarantees that alternatives will actually be developed for the services that are being broken down. Currently adding to these concerns are mental health care budgets cuts, the introduction of obligatory partial out-of-pocket payments in mental health care and changes in the benefit system.

Suggestions for national measures that could remove current barriers and facilitate and promote the development of community support can be summarized into four categories:

- *Framework* - It is suggested that a national framework should be made, that describes a region's maximum capacity of inpatient and residential facilities and the region's minimum capacity of outpatient and community support services (for instance FACT and IPS).
- *Solid funding of participatory support services* - Funding of support in the field of social contacts, day activities, education and employment should be made much less complex and less permissive. Structural funding and clear entitlement should be created. WMO-budgets should be linked to performance measures (for instance concerning local cooperation), parts of the budgets should be ring-fenced for persons with severe mental health problems and entitlements should be created for long-term individual social support. Some interviewees promote the installation of individual recovery coaches: preferably well-educated professionals with consumer experience.
- *Integral funding*- Possibilities should be explored to create integral budgets for the support of persons with severe mental health problems across sectors and funding systems. Criteria for integral funding should be made explicit in terms of clients characteristics and needs and in terms of requirements of the budget holder.
- *Comprehensive policy plan*- national government should formulate one clear and consistent, cross-sectoral plan for community support and social inclusion of persons with severe mental health problems. The plan should include measures to create an inclusive climate, an adequate system of entitlements to support services, clarity about (coordinating) responsibilities on an individual, local and national level and effective financial incentives in all sectors to cooperate in and contribute to the social inclusion of persons with severe mental health problems.

5 Conclusions

5.1 Comparison of national policies and systems and their implications

The previous chapters show that there are similarities but also some important differences in the Danish, English and Dutch national policies and national service systems regarding community support and social inclusion of persons with severe mental health problems. These similarities and differences resonate in the community support systems of Aarhus, Nottingham and Alkmaar, although each of these regions also has its own specific characteristics, compared to other regions in the respective countries. Moreover, the appreciation by regional key persons of the incentives of the respective national systems and policies, shows the merits and flaws of some specific national characteristics, but also some general tendencies across the countries. In this paragraph an inventory and an analysis will be made of the main similarities and differences on a national and regional level and in key persons' perspectives on national policy and system incentives and disincentives for community support.

National systems and policies

The main characteristics of the national mental health care systems and the national policies concerning the development of community support and social inclusion of persons with severe mental health problems in Denmark, England and the Netherlands can be summarized as follows.

Denmark

The current mental health care system in Denmark is the result of both a gradual, long-term process of deinstitutionalization and a radical administrative reform in 2007. The deinstitutionalization process has led Denmark to a relatively low psychiatric inpatient capacity, although the level of residential facilities is relatively high. The structural reform in 2007 has led to a dual mental health care system, where social psychiatric and housing facilities became the responsibilities of the municipalities and the core 'treatment' business of secondary mental health care became the responsibilities of regional authorities.

As a result, Denmark counts five regional health care authorities that are responsible (among others) for psychiatric hospitals and psychiatric outpatient clinics. These outpatient clinics are often located in community mental health centers, together with the municipal services. There is a tendency, however, of the clinics retreating to the hospital site (see below). Regional mental health care staff mainly consists of psychiatric nurses and psychiatric, medical or therapeutic specialists. The *municipalities* in Denmark are responsible for general social services and also, since 2007, for housing facilities for

persons with severe mental health problems, day and night care facilities, social psychiatric services (with the exception of the treatment aspects of social psychiatry) and facilities for day activities, social contacts and participation (including school, work and leisure). The staff of the municipal social psychiatric services almost exclusively consists of Mental Health Social Workers (MHSW). The estimated share of the municipalities in total mental health care expenditures is 40%. There is a considerable overlap in client population of the regional and municipal system, especially with respect to persons with severe mental health problems.

Health care funding is based on national (and for a small part local) taxation. Overall municipal and regional budgets are for the largest part allocated by the state. However, both the regions and the municipalities are at relatively great liberty to decide what parts of the budgets are spent on mental health care and specific mental health care services (no ring-fencing of mental health care budgets).

Community support and social inclusion of persons with severe and long term mental health problems are attended in Danish national policy documents. Several measures have been taken to arrange individual or group entitlements on work, education and housing. Cooperation between care providers on an individual and a local level is promoted through several measures, such as the integrated social and mental health care coordination plan, which is mandatory for persons with severe mental health problems. Also joint planning and agreements between the regions and the municipalities are prerequisites for funding. A related measure concerns the municipalities' obligation to pay for a prolonged psychiatric hospital stay if adequate social psychiatric help would be a good alternative but is unavailable.

England

An extensive deinstitutionalization process in the past decades has led England's psychiatric inpatient capacity to become one of the lowest in Europe. Community alternatives have been developed in the course of very directive and prescriptive national policies and consist of general community mental health care and specialist teams for early intervention, assertive outreach, crisis resolution and community rehabilitation. Outpatient mental health care is provided by the regionally organized, statutory mental health trusts. The trusts are part of the National Health Services (NHS), an almost fully tax-funded health care system, under direct control of the Department of Health. NHS-funding of the mental health trust is for the largest part (approximately 80 %) through regional health care commissioning and for a small part (social care) through the local authorities.

Community support in the fields of housing, independent living, social contacts, education and employment is provided by the trusts and by non-statutory, non-governmental organizations. These non-statutory organizations draw their incomes not only (and often not at all) from mental health care funding, but also from other local or national social care or housing budgets, (temporary) innovation funds, charity funds or other sources. In the

past decade some large scale national innovation programs and funds have been important in the development of community support, for instance the *Supporting People Program*.

Also in the past decade mental health care policy in England has moved from a directive approach, aimed at the development of a solid community care structure, towards the promotion of wider social inclusion and recovery goals. Illustrative for this policy development are the introduction of a comprehensive national anti-stigma campaign and a national recovery-program. Lately, mental health care and community support are increasingly becoming under the influence of broader reforms and reform plans for health and social care. At the core of these reforms are a transfer of responsibilities to the local level, the introduction of market incentives and an increasing involvement of the private sector. One important element of these reforms is the transfer of nationally guided PCT-commissioning to local commissioning consortia of clinicians.

The Netherlands

The Netherlands belong to the European countries with the largest psychiatric inpatient and residential capacity. Recent trends indicate a modest but still continuing increase in inpatient capacity and an accelerating growth of residential (sheltered housing) capacity. Mental health is mainly provided by 31 integrated mental health care organizations.

Despite the high inpatient and residential capacity, community care for persons with severe mental health problems is available in the Netherlands, mostly consisting of regular social psychiatric services of the integrated mental health organizations. Additional services in the fields of participation and social inclusion mainly consist of a range of various small scale projects and facilities of mental health care organizations, consumer organizations, and sometimes partners in social care or sheltered or supported employment.

Community support and social inclusion have not been major issues on a national policy level in the past decade in the Netherlands. Attention was concentrated on the introduction of market incentives, as a means for cost containment and quality improvement in health care in general. As a result, since 2008, commercial insurance companies have a central role in mental health care commissioning under the Health Insurance Act (ZVW), which covers approximately two thirds of mental health care expenditures. Health insurers also are the administrators of the Special Medical Expenses Act (AWBZ), covering the largest part of the rest of mental health care expenditures, especially long-stay and residential care.

Central to the latest developments in the Netherlands is that health insurers have noticed the relatively high inpatient capacity of the Netherlands and have begun formulating targets for downsizing inpatient capacity in their yearly negotiation cycles with mental health care providers about next year's contracts. Meanwhile, on national policy level, a trajectory has been launched to decentralize responsibilities from the long-term

care funding system of the AWBZ to the Social Support Act (WMO). The WMO is administered by local authorities and covers a broad (non-ring-fenced) range of social services for a wider population. Especially AWBZ-services in the field of social support (supported housing) and day-activities are being transferred.

Comparison of national systems

Regarding national system characteristics, the results of our study show that in all three countries some form of regional or local organization of community support prevails and that local or regional mental health care organizations play a crucial role in these regional systems. In all three countries, mental health care on a regional / local level is dominated by one (England and the Netherlands) or two complementary (Denmark) regional or local mental health care organizations. Except for Danish municipal mental health care providers, these organizations are not exclusively oriented on community care and community support for persons with severe mental health problems, however. They provide the full scope of mental health care services to persons with severe and mild mental health problems (inpatient, residential and outpatient services). In addition, in all three countries *community care* (or mental health home care) can be considered an element of the national health care system and of the services of the mental health care organizations. As *community support* (services aiming at social participation and social inclusion) is concerned, more actors and more funding systems come into play, especially local actors and most of the time also funding systems with a more prominent role for local parties.

So far the similarities. The main differences in the systems of the three countries are in levels of centralized or decentralized administrative control, levels of market incentives and involvement of local authorities.

England traditionally has the strongest nationally controlled system, characterized by a prescriptive policy concerning availability and organization of services. Also commissioning and funding in England has until recently been through (representatives of) national authorities. In Denmark and in the Netherlands, responsibilities and control are more decentralized to regional and local authorities and to health insurers respectively. The level to which market incentives have been introduced is the largest in the Netherlands, where competing private health care companies contract services from competing (mental) health care providers. Because of traditional regional monopolies of integrated mental health care organizations, all providers have thus far been contracted. But catchment area boundaries are fading and supra-regional activity and competition are increasing. As the involvement of local authorities is concerned, Denmark stands out with social psychiatric care and housing being funded and controlled almost fully by local authorities since the Structural Reform of 2007. In England the role of local authorities is somewhat more modest (local authorities do provide social services for persons with severe mental health problems but social psychiatry as such is still part of the health care system and the mental health care providers). In the Netherlands local authorities have so far hardly come into the mental health care picture at all.

Interestingly, while levels of central control and prescriptive policy, market incentives and local authority involvement greatly differ across the three countries, a convergence seems to be taking place lately in all three aspects. In England reform plans are to transfer national responsibilities to the local level, introduce market incentives and increase involvement of the private sector. In the Netherlands, market incentives and private health care insurers already have a prominent role. However, local authorities were hardly in the picture until recently but will be in the near future, as a result of the transfer of responsibilities from the health care funding system to the locally administered Social Support funding system. In Denmark, decentralization of responsibilities and especially transfer of services to local authorities has moved the farthest. Introduction of market incentives is not so much a national policy as well as a probable result of the decentralized system on a local level.

To conclude, national systems for mental health care and community support in England, Denmark and the Netherlands greatly differ in levels of central control and the involvement of the private sector and local authorities. However, they currently seem to share a common tendency, partly ideologically motivated as it seems, towards decentralization, the transfer of service responsibilities to the local level and the introduction of market incentives.

Comparison of national policies

Apart from the funding and administrative control systems, differences between the countries are most apparent in their specific community care and community support policies. This shows most clearly in national inpatient and residential capacities.

Deinstitutionalization and the development of community care have been very explicit policy goals in England and in Denmark in the past decades. Specifically in England the development of community care for persons with severe mental health problems has been enforced by an explicitly prescriptive national policy. To a lesser extent the same is true for Denmark. In the Netherlands, incentives for deinstitutionalization and for the development of community care have been much more non-committal and have in fact faded out since 2002. As a result, the Netherlands stand out with a very high number of psychiatric beds and residential facilities, while inpatient and residential capacity in England is one of the lowest in Europe. Denmark holds a position in the middle, with relatively low psychiatric inpatient capacity and high residential capacity (sheltered housing, nursing homes).

When we consider community care as a first step and broader community support as a second step towards social inclusion, again especially England has made some further moves in recent years, at least in national policy vision and statements. Social inclusion and involvement of a wider society in the community support of persons with mental health problems is at the core of recent English policy documents. Several innovation programs and national campaigns have supported these policies, although implementation is much less prescriptive and enforced as compared to the previous

stage of downsizing inpatient capacity and developing community (home) care services. Also in Denmark, social inclusion has grown into a central issue in policy documents. Several measures have been taken to arrange individual or group entitlements on work, education and housing and to promote cooperation between relevant providers. In the Netherlands, downsizing inpatient capacity has grown into a national issue only recently, but no specific targets and no social inclusion policy plan or policy measures have been formulated yet.

To conclude, social inclusion ambitions and measures differ across the three countries. One common aspect of the current situation, however, is that each of the three countries experiences pressure on public expenditures. Whereas in principle this pressure could perform as an extra incentive to social inclusion ambitions, for several reasons and as will be illustrated below, it does not so in practice.

Regional community support systems and services

As said, the similarities and differences of the national policies and systems in Denmark, England and the Netherlands resonate in the community support services and systems of Aarhus, Nottingham and Alkmaar. Each of these regions also has its own specific characteristics, however, compared to other regions in the respective countries. Specific to all the three regions is the fact that they each have a long tradition of innovations in social care and social psychiatric care for persons with severe mental health problems. They are each considered frontrunners, in this respect, in their respective countries. As socio-geographical characteristics are concerned, all three regions are combined urban-rural areas, with a middle-large town in its centre.

The main characteristics of the community support services and systems of the three regions can be summarized as follows.

Aarhus

As the rest of Denmark, Aarhus since 2007 has a dual mental health care system. Social psychiatry and social support services are provided by the municipality of Aarhus, inpatient services and outpatient psychiatric treatment and counseling are provided by Aarhus University Hospital, which is controlled by the regional health authorities.

Through the years and compared to other regions a broad range of services has been developed in Aarhus in the fields of housing, supported living, day activities, participation, education and work. Consumer organizations are relatively strongly represented and engaged in these activities. Moreover, an extensive recovery education and implementation program has been launched throughout the municipal mental health care system in recent years. The impression is that the program has had a profound impact on perspectives and activities of professionals and has contributed to a shift of attention towards clients' potentials instead of impairments. A strategy has been made for the continuation of the recovery program in the next years.

The organization of the local community support system in Aarhus can be described as a relatively open network, be it a network that has developed from a relatively long and strong tradition of local cooperation. There is no specific mandated coordinating agency concerning community support for persons with severe mental health problems, but there are a few specific cooperation arrangements. One of these is a monthly meeting of representatives of a core group of partners, discussing practical matters. Once in every three months a similar meeting takes place on a higher executive level, between managing directors. Next to that, the obligatory Health Agreement between the region and the municipality helps to exchange plans and attune services. The obligatory individual coordination plan across health and social care for persons with severe mental health problems is also believed to be helpful for promoting cooperation.

Key persons in the region believe that there is still a lot to be done with regard to community support and social inclusion of Aarhus inhabitants with severe mental health problems, but they also believe that there is a solid base from where to proceed. Still, there are also some concerns, as will be illustrated more extensively below. Most of these concerns have to do with policy and system characteristics on a national level, but one specific local concern is that cooperation threatens to become more complicated as a result of new policy plans of the regional health authority. Regional and municipal mental health care workers in Aarhus kept working together in several community mental health centers since the 2007 reform. However, as a result of a new recent policy plan of the region, emphasizing a predominantly biomedical approach of mental health problems, outpatient regional mental health care is being retreated to the hospital site and cooperation between the two mental health care systems may become less evident, at least on an operational level.

Nottingham

The basic structure of Nottingham's community mental health services for persons with severe mental health problems resembles the general structure in English mental health care, as prescribed by the National Services Framework of 1998. This means that there are general community mental health care teams and specialist teams for early intervention, assertive outreach, crisis resolution and community rehabilitation. Outpatient mental health care in Nottingham is provided by the Nottinghamshire Healthcare NHS Trust (NHCT), which is part of the National Health Service.

Specific for Nottingham, as compared to other regions in England, is an even lower inpatient capacity than national average. Also specific for Nottingham is a strong tradition in social support for vulnerable people and a strong consumer movement. Especially the non-statutory sector has been to a great extent (co-)responsible for the development of services for vulnerable persons, including persons with severe mental health problems, in the areas of (supported) housing and participation (including support in finding and preserving employment). Nottingham is also considered a national precursor in the introduction and implementation of a recovery approach in service provision. It has

opened a Recovery Education Center in 2011. It also participates as one of the pilot sites in a national recovery promotion program.

As in Aarhus, there is to this point no specific central coordinating, planning or policy agency or a joint plan of relevant stakeholders concerning community support and social inclusion of persons with severe mental health problems in Nottingham. Also as in Aarhus, there is a lot of cooperation, however, on several levels. Until recently health care and council (social care) commissioners engaged in joint needs analyses and strategic planning. The mental health trust has formalized partnerships and joint services with Framework, the most important non-statutory provider of supported housing and other social support services. In addition, Framework itself has a strong tradition of community networking, engaging community facilities and local health care and social care agencies.

In 2009, the Local Services division of the NHCT tried to take a next step in local cooperation, by preparing a 'social inclusion strategy', in which a program for regional co-ordination and management of community support services is outlined and a multi-agency partnership of key partners is proposed. Some elements of the program have actually been put into practice. Among these elements is, for instance, an anti-stigma campaign, carried out by the NHCT in cooperation with other local organizations in 2010. However, the ambition of the Social inclusion strategy as the start of a comprehensive and well-coordinated interagency venture does not seem to have been fully realized yet.

As in Aarhus, key persons in Nottingham believe that a solid base has been laid for community support and social inclusion of persons with severe mental health problems in the city and the county. They also believe, as will be illustrated below, that national policies have helped a lot in this respect. But key persons in Nottingham also believe that there is still a lot to be done and there are concerns that progress might be hindered by recent policy developments.

Alkmaar

The region of Alkmaar is also a somewhat atypical region compared to national - Dutch - standards regarding mental health care and community support services for persons with severe mental health problems. It has, compared to national averages, a relatively low inpatient and residential capacity. Its main mental health care provider, GGZ Noord-Holland Noord has very explicitly adopted community care in the form of FACT as the core of its long-term care services. FACT-teams are characterized by their broad, integral, multidisciplinary, flexible, neighborhood-based services. GGZ NHN has also adopted a recovery-approach (although key persons indicate that a definitive breakthrough in traditional psychiatric mental health care culture still has to take place).

In addition to the FACT-teams, GGZ NHN is involved in a range of community support services in the field of day time activities, social contacts, education and vocational rehabilitation. A pivotal role in these services is played by the activity centers of GGZ

NHN itself. Since 2008 GGZ NHN also offers vocational rehabilitation services through the method of Individual Placement and Support (IPS). Nine IPS workers of the regional (non-categorical) organization for sheltered work and job coaching are detached at the FACT-teams of GGZ NHN. Some other community support services for persons with severe mental health problems are provided by other organizations - often in attunement with GGZ NHN workers.

GGZ NHN traditionally invests a lot in local cooperation, for instance with regular home care, housing corporations and vocational organizations. GGZ NHN also enables some employees to actively perform as community development workers. In general, GGZ NHN is making more than average efforts to lift the attention for community support and social inclusion in the region to the level of a widely recognized common cause, involving all relevant local stakeholders. Crucial to these efforts and relatively unique from a national perspective is the backing from the dominant health insurer in the region, that permits inpatient savings to be invested in outpatient care and assists in trying to involve other funding agencies (local authorities) and stakeholders in the development of an adequate regional community support system.

In 2009, GGZ NHN has taken the initiative to lift the regional cooperation in the field of community support to a more structural level through the establishment of the Regional Transition Group (Regionale Werkgroep Transitie GGZ NHN). Crucial, however, is the apparent reluctance so far of local authorities to participate. This might be a substantial risk for future developments because, according to national policy plans, budgets for long term support in independent living and day-activities will be transferred from the national health system to local authorities. With this transfer individual entitlement and ring-fencing of budgets will disappear and the further development or even continuation of existing support services will become fully dependent on the cooperation of local authorities and willingness of local politics.

Comparison of the regions

As said and as illustrated, all three regions have a long-standing ambition of developing adequate community support services for persons with severe mental health problems. Also all three regions have developed a range of community support services and put efforts in local coordination of these services on an individual and organizational level. Interestingly, the recovery-approach has also been adopted by the relevant organizations in Aarhus, Nottingham and Alkmaar and implementation programs are running in each of these organizations.

Main differences between the regions can be found in capacities, the role of the mental health care system and the involvement of local authorities. Comparing total inpatient and residential facilities of the three regions, Nottingham's capacity is by far the lowest. In contrast to national figures, not Alkmaar but Aarhus has the highest capacity (due to a relatively large capacity of residential facilities in Denmark and especially in Aarhus).

Alkmaar also stands out with an all-embracing role for the regional mental health care provider (partly as a result of the Dutch mental health care system and notwithstanding ambitions to involve the local community). Local authorities hardly come into play in Alkmaar. In Aarhus the situation is almost the other way round, with in fact two mental health care systems – run by the Aarhus University hospital and the municipality respectively. Traditional mental health care, as represented by the Aarhus University Hospital, plays a relatively small role in community support while municipal social psychiatric services play a bigger role, alongside other municipal services in the field of housing and participation. In this respect, Nottingham holds a position in the middle, with community care mostly provided by several teams of the main regional local mental health care provider, but where non-statutory organizations and local authorities also provide services to persons with severe mental health problems.

Apparent from the description of the three regions is also that community support services for persons with severe mental health problems are on the interface of the predominantly nationally organized, well-structured health care systems and the predominantly locally organized, less-structured social care and welfare systems. Exact boundaries between these two systems as such, differ between the regions and are dependent on national systems. However, as will be seen below, in all three regions and notwithstanding local ambitions, this intermediate position seems to entail risks for the stability of community support services for persons with severe mental health problems.

Regional key persons' perspectives on national incentives and disincentives for community support

None of the three regions has comprehensive and representative data on the actual quality of services and quality of life of persons with severe mental health problems in the region. Still, in all three regions key persons believe that a lot of progress has been made in the past years and decades in the development of regional community care and community support services. Also in all three regions key persons believe that there is still a lot to be done. Especially the persistent dominance of symptom- and impairment-oriented psychiatric perspectives and practices in mainstream regional mental health care is still considered a very important barrier that needs a lot of effort to overcome. Stigma is another one, especially stigma in the mental health care system itself. Anti-stigma campaigns but also education of mental health care staff are crucial in this respect. Key persons in Aarhus, Nottingham as well as Alkmaar have high hopes of the new recovery-approach and recovery-education programs, although some also mention the risk of recovery turning from the original consumer-led emancipation perspective into yet another professional mental health care method. In this respect, not so much consumer involvement, but consumer control and genuine, open encounters between persons with severe mental health problems, professionals and other members of the local community, are said to be crucial for future developments.

Next to that, key persons in all three regions mention a range of conditions for community support and social inclusion on a national policy and system level. But before we go into that, we will first evaluate the extent to which, according to key persons of the three regions, past national policies have so far been helpful and the extent to which recent and current policy and system characteristics are believed to be helpful for the future chances of community support and social inclusion.

National incentives and disincentives for community support in Denmark - Aarhus

According to key persons in Aarhus, several characteristics of the national Danish policy and mental health care systems have been helpful in the social inclusion of persons with severe mental health problems so far. In general, key persons appreciate the past emphasis on deinstitutionalization and the recent pleas for social inclusion and cooperation in national policy documents. Many believe that regulations for individual and group entitlements for persons with mental health problems in the fields of work, education and housing have been to a certain extent effective. That is also the case for the several instruments in the Danish system to promote cooperation on an individual and regional level: the obligatory coordination plan for persons with severe mental health problems and the obligatory health agreement between the municipalities and the regions.

Key persons are more ambiguous about the dual mental health care system. According to some, the transfer of social psychiatry to the municipality has increased chances for local cooperation with other relevant municipal departments (education, housing, work) (although others remark that also within the municipality the financial, organizational and ideological dividing lines between departments can be strong). However, the dual system is also believed by many to hinder integrative, comprehensive and continuous care.

In fact, at the time of the study, there is talk of a substantial risk of municipal and regional mental health care in Aarhus drifting apart. Indications are that the recovery education program is an exclusively municipal venture, while the regional authorities' mental health care policy is aiming at psychiatric specialization and economizing services by withdrawal from the community mental health centers. Concerns are that the gaps between the respective systems and services will grow wider, integrated services will become harder to realize and especially the most vulnerable people will fall through the cracks. Alleged incentives for a shift of attention away from persons with the most severe mental health problems enforce these concerns. These incentives are believed to be in the relatively low education level of municipalities' mental health social workers, in the recovery-paradigm being misused to increase participatory pressure and in production and patient turnover pressure in regional psychiatry.

Another national policy barrier to the further development of community support or even the continuation of existing services is that decision making on budgets and required services is to a great extent decentralized to the regions and the municipalities. This can be a potential for innovation in prosperous times, but is at the same time proving to be

a great risk in current times of economic crisis, as budget cuts are especially taking place in the municipalities' support services (sometimes legitimated under a social inclusion motto). In general, current budgetary tightness is also said to lead to disinvestments in cooperation and to erosion of individual and group entitlements in the fields of housing and work.

National incentives and disincentives for community support in England - Nottingham

Of the three regions, key persons in Nottingham are the most positive about the incentives of past national policies on the development of community care and community support for persons with severe mental health problems. Especially the directive approach through clear funding criteria (in structural funding as well as in temporary innovation funds) is believed to have paid off. For instance the National Services Framework of 1998 has helped create an adequate and solid national structure of community mental health care. Specific innovation programs in the fields of (supported) housing and employment have also been successful in the development of community support services, also in Nottingham. This success was due, according to key persons, to the combination of solidly ring-fenced (cross-departmental) budgets with the funding requirements of local partnership.

Key persons in Nottingham also believe that the policy objective of community support has gained content by more recent national policy documents on social inclusion, recovery and the involvement of the educational and employment sectors. One of the interviewees ascertains that, with these recent policy papers and their emphasis on wider social inclusion, empowerment, emancipation and recovery goals, "for the first time ever we got absolute consistency between what policy is commending and what people want who have themselves experienced mental health problems". In general, key persons agree that these policy developments and statements have much helped to create the atmosphere where new initiatives in community support, social inclusion and recovery in Nottingham have been able to evolve in recent years.

Key persons in Nottingham also mention several barriers in national system and policy characteristics, however, of which some are long-standing and some new. As a main barrier to the further development of community support, key persons point at the vulnerability of the fragmented and non-structural funding of community support services in the fields of supported housing, social contacts, day-activities, education and work (as opposed to the much more solidly structured and funded community care teams). Key persons indicate that this vulnerability is currently being uncovered in a rather unambiguous way. More specifically and as a result of the political and economical circumstances, Nottingham currently witnesses severe budget cuts in this area, especially in supported housing. Day-centers have also recently been closed (the status of individualized alternatives is not clear yet). An additional concern is the potential retraction of the locally funded social workers from the multidisciplinary mental health care teams of the trust.

Key persons in Nottingham also believe that the recently developed national policy goals of social inclusion and recovery help create the right mind-set, but lack the solid implementation plans that accompanied the earlier development of the community care teams. Existing barriers to social inclusion are not seriously addressed and impediments are even increasing. Concerns are especially expressed that the vulnerability of community support funding for persons with severe mental health problems will in fact be increased by current policy plans to transfer responsibilities to the local level and to the market. The reforms might result in individual interests drifting away from the general social and economic interest of social inclusion, thereby discouraging investments in the further development of local community support systems and in cooperation and coordination.

National incentives and disincentives for community support in The Netherlands - Alkmaar

According to key persons in Alkmaar, the development of community care and community support in the region has benefitted from several national innovation programs throughout the years. Especially the earlier *Care Innovation fund* is believed to have had substantial and positive impact. GGZ NHN has also profited from the recent *Transition Program Long-term Care* with which some innovative regional projects have been financed. However, the impression of interviewees is that the overall contribution of national policy and system characteristics to the development of community support for persons with severe mental health problems in the Netherlands and in Alkmaar in the past decade has been very modest. Community support and social inclusion have in fact not been very prominent national policy issues. At the same time, there have been and still are some specific barriers.

As comments on national policies from the Nottingham and Aarhus regions mainly focus on the vulnerability of existing community support services, key persons in Alkmaar believe that barriers in the Dutch system and policy first of all concern the previous step: the transfer of inpatient capacity to community care. Throughout the years and until now the mental health care funding system is characterized by positive incentives for inpatient and residential care. At the other end of the scale are high economic risks for organizations that try to deinstitutionalize and obtain inclusive policies. Also administrative procedures for funding of support trajectories in the field of day activities, education and employment, are very time-consuming, more so because these procedures have to be followed for each individual trajectory.

In general, the organization of comprehensive and coherent support for persons with severe mental health problems is believed to be hindered by the fact that these support services are dependent on a range of funding systems, each with its own procedures and each with a tendency of responsible agencies to restrict access and refer to other funds. Mental health care alone is funded through four systems. This makes it hard for clients to get access to the right services at the right time and complicates the provision of

coherent and continuous care and the funding of integral services as FACT. Key persons point to the fact that this fragmentation of funding systems is mirrored in the diffusion of responsibilities on a regional and national authority level, resulting in a lack of a key problem owner and a lack of coordination and planning.

In this context, the renewed attention on a national policy level for psychiatric bed reduction and the transfer of responsibilities to local authorities is received with ambivalence. More so because neither the decentralized, competitive health care funding system nor the non-ring-fenced social support funding system of the Social Support Act, offers guarantees that alternatives will actually be developed for the services that are being broken down.

Comparison of national incentives and disincentives

Key persons in the three regions believe that a good base for community care and community support has been built in Aarhus, Nottingham and Alkmaar respectively. The extent, to which national policies are believed to have helped create what has been built so far, differs across the regions. Key persons in Nottingham are the most positive, those in Alkmaar somewhat more critical. As far as national policies are being valued as constructive to community care and community support, most positively valued are a clear vision, directive funding, ring-fenced budgets, clear entitlement, solidly funded innovation programs and financial incentives for cooperation.

Key persons also believe that there are good (economic) arguments and a big potential for the further development of effective and comprehensive community support systems. However, this development currently seems to be frustrated by some old and some newer policy and system barriers. In part, these barriers again differ across the countries, with the Netherlands standing out for its strong, although unintended financial incentives for inpatient care and against integrated community care. But there is also a lot of congruence between the countries concerning current impediments. In short, these common impediments are about the vulnerability of community support services between health and social care systems, the lack of ring-fenced budgets, the lack of key problem ownership and the tension between the ambition to involve the wider community and the ambition for coherent and integrated care.

Concerning recent policy developments, 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 parties (with the Netherlands in the front). Specifically this combination of developments is considered a risk for the further development and even continuation of existing community support services.

In the next paragraphs we will shortly elaborate on these findings and try to reach some general conclusions. In the last paragraph some suggestions for future national policies will be made, as put forward by the regional key persons.

5.2 Conclusions on incentives for community support

The comparison of the three regions and the three countries shows that the main challenges regarding the development of community support systems for persons with severe mental health problems are much the same across countries. Differences are mainly in the extent to which solutions are sought on a national policy level and in the direction of these solutions.

One of the main common challenges is that provision and funding of community support services is on the interface of the predominantly nationally organized, well-structured health care systems (with clear entitlements to consumers) and the predominantly locally organized, less-structured social care and welfare systems. One consequence is that the objectives of community support and social inclusion lack a clear key problem owner. There is no agency or department taking full responsibility. Also no agency is fully accountable for failure. Another consequence is that funding community support services is a matter of constant acquisition, lobbying, searching for grants and trying to bend regulations. Many services are dependent on composite budgets from several funding systems and from temporary budgets. This not only hinders the development of services and of know-how, it is also very time-consuming and inefficient.

On a more fundamental level, the key challenge seems to be that community support and social inclusion of persons with severe mental health problems require the involvement of a growing number of community facilities and organizations, while this same development puts a pressure on preserving clarity about responsibilities, coherence and continuity in support services and solidity of funding. Community support policy requires measures to arrange for this clarity, solidity and coordination. As a matter of fact, some measures that have been taken in the past by national authorities, meet these criteria. In England the National Services Framework has been an example of a clear and prescriptive regulation of services and responsibilities (although restricted to the care domain). In Denmark several measures have been taken to enforce coordination and cooperation on an individual and organizational level. In the Netherlands, the mental health care provider in Alkmaar has taken up its own measures by developing the FACT-teams, which take full responsibility that clients receive coherent care on all life domains.

The study results show that, from the perspective of key persons in the regions, these measures help, but that a much more consistent and consequent policy is necessary with respect to responsibilities, coordination and funding of community support for persons with severe mental health problems.

The results also show that each of the three countries currently witnesses a tendency to decentralize responsibilities to local politics and to introduce market incentives. These developments do not as such have to be harmful for community support and social inclusion. They will be, however, when they are not accompanied by a national policy

regulating responsibilities, organizing coordination of services and guaranteeing solid and structural funding. In absence of such a policy risks of decentralization are that persons with severe mental health problems will not be on the priority lists of local politics, entitlements and ring-fenced budgets will evaporate and large interregional differences will appear (as is already partly the case in Denmark). Risks of the introduction of market incentives are that health care expenditure growth will accelerate (as a result of competitive pressure to expand markets) and that funds will move towards the large reservoir of profitable and relatively light disorders at the cost of services for persons with severe health problems (as is currently feared in the Netherlands).

Decentralization and the introduction of market incentives can be helpful for community support and social inclusion, however, provided that they are accompanied by additional policy measures. Local authorities have the potential to play a very important and stimulating role, as a key player in local society. But to make them take up this role, responsibilities and expected efforts and services of local authorities towards persons with severe mental health problems will have to be made as explicit as possible. Also individual entitlements on local support services should be formulated and funds should be ring-fenced. (Key persons in Nottingham remark that to a certain extent the English system met these criteria until recently).

As the potential of market incentives are concerned, it is of relevance that in all three regions key persons indicate that measures that have financial consequences have by far the greatest impact. (Prescriptive measures without any financial consequences are considered relatively weak in their effects.) In this respect, competition for funds can be a very strong tool, provided that market incentives and award criteria are in line with the requirements for the development of adequate community support systems and social inclusion of persons with severe mental health problems. This could for example mean that reimbursement systems based on psychiatric diagnoses and impairments should be replaced by systems that reward adequate community care (instead of inpatient care), a recovery-approach, strong local cooperation and partnerships, etc. Such a system could also reward (instead of complicate) integrated care for the most vulnerable clients. Perhaps it could in general allow some flexibility in budget spending, once budgets have been assigned. And if it is too ambitious for immediate implementation, innovation and stimulation programs based on the same award criteria could pave the way for such a reimbursement system. In fact some past innovation programs in the Netherlands (Care Innovation Program) and England (Supporting People Program) have been set up on the basis of roughly these criteria and have been very successful, according to key persons.

Essential is that decentralization and the introduction of market competition entail the risk of individual interests drifting away from the general, national economic and social interest of social inclusion of persons with severe mental health problems. Even when individual organizations and providers appreciate these general interests and even when

they know what their contributions could be, chances are that incentives stemming from local political and market contexts may force them to act otherwise. Crucial is therefore that incentives in the funding systems are such that individual interests are in line with the general interest of adequate community support and social inclusion of persons with severe mental health problems.

The current situation, however, is still far away from that, in all three countries. As a consequence of the vulnerable funding conditions and in absence of a clear and responsible agency or authority, public expenditure cuts currently find an easy way to community support services for the (mostly relatively non-assertive) population of persons with severe mental health problems. This entails a great risk of frustrating and even turning back a range of hopeful developments on an operational level. In the end, it might result in a lower participation of persons with severe mental health problems in society and in higher costs of care and costs of social benefits.

Social inclusion is the only sustainable answer to economic costs of severe mental health problems. This makes the urgency of investments in the development of well-organized and solidly funded community support systems even greater in times of economic recession.

5.3 Recommendations

The results of this study suggest that the national, social and economic importance of good support and social inclusion of people with severe mental health problems requires an authoritative advocate and organizer on a national government level. The scope of this advocate should transcend individual levels of influence and current individual interests of providers, local authorities, private parties, commissioning agencies and separate ministries. This national advocate should join forces with all relevant parties to develop an integrated and intersectoral national policy that defines values, direction, responsibilities, structure and funding of services. It should especially define what is necessary to bring individual interests of relevant parties in line with the general interest of social inclusion. In this way it should facilitate, stimulate and, where necessary, structure community support and social inclusion of persons with severe mental health problems.

Some elements of such a national policy are already present in the three countries, although to a different degree and in different respects. But in all three countries there is also still a lot to be won in terms of comprehensiveness, coherence, directiveness and implementation of national social inclusion policies. Key persons in the regions have made a range of suggestions for the (further) development of such national policies. Accents in these suggestions again differ across countries, regions and individual key persons. However, there is also a broad common set of recommendations to be derived from these individual and regional suggestions. These recommendations are about the

need for a clear policy vision, a national community support framework (concerning responsibilities, entitlements and services), solid funding and inclusive financial incentives, special attention to integrated care for the most vulnerable clients and innovation programming.

National policy vision on social inclusion

Key persons in all three regions believe that a broad and genuine acknowledgement and promotion on a national government level is required of the social and economic benefits of community support and social inclusion of persons with severe mental health problems, not only for those involved but for society as a whole. This acknowledgement should not be restricted to the health care department but should have cross-departmental and broad political support. This broad support should help to line up policies and to prevent that one department is offsetting what another is promoting. It should also lay the foundation for investments that do not have direct pay off for the investing department but that do contribute to benefits in other departments and in society in general. This national vision should also help create an inclusive climate across society and should actively be disseminated among others through supporting anti-stigma programs and especially through facilitating and stimulating (funding) an active role of persons with severe mental health problems themselves. Central issues in this dissemination program should be people's wishes to lead a normal private and social life and people's experiences with what is needed to do so.

National framework of responsibilities, entitlements and services

A national framework should be developed, defining exact responsibilities of national, regional and local authorities and other relevant agencies (commissioning and funding agencies, including private health insurers) concerning community support services and social inclusion of persons with severe mental health problems. Cooperation in community support should be made mandatory on all levels (for instance between the several funding agencies). Especially end responsibility for coordination on a national, local and individual level should be addressed in terms of coordinating agencies and methods. As far as necessary to involve other relevant organizations, the coordinating agency should have a mandate on the deployment of several financial resources.

The framework should be as much as possible based on existing evidence of effective arrangements. As far as possible, required service capacity on a national and regional level should be described. Also entitlements of individuals with severe mental health problems should be made explicit, not only entitlements to services but also to housing and work.

Structural funding and inclusion incentivizing reimbursement systems

Directive implementation of community support and social inclusion policies primarily asks for solid funding and adequate financial incentives. Especially flexible, long-term and coherent, individual support in independent living, social contacts, education and

employment should have a solid (possibly joint interdepartmental) funding that is ring-fenced and structural. Such a system should be backed up by general funding prerequisites, enforcing an inclusive approach in service provision and organization. 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. They should also allow some flexibility in budget spending, once budgets have been assigned. Outside of the services system, inclusion in education and work can be financially incentivized by bonus systems to educational organizations and employers.

Integrated care for the most vulnerable clients

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. Such an integral, cross-sectoral budget can enhance coherence, efficiency and continuity and can reward integrated care for the most vulnerable clients. Criteria for integral funding should be made explicit in terms of clients' characteristics and needs and in terms of requirements of the budget-holder. Budgets could for instance be linked to a formal coordinating responsibility. In case of a need for intensive, integral care, the coordinating role and the budget could be assigned to a community support team, taking integral responsibility for (delivering or purchasing) adequate support on all life domains. In other cases, the budget could be assigned to the organization or professional that is the closest involved in the daily support of the individual client (primary care professional, recovery coach) or to the client system itself.

Innovation programs

As the further development of a comprehensive national social inclusion policy will need preparation, innovation programs and funds can have a crucial role in exploring, developing or expanding the desired service provision and in leading the way for mainstream health and social care systems. Innovation programs can in fact play an important role in a wide range of community support and social inclusion issues, such as: promoting the implementation of a recovery-approach, (re)-education of mental health care staff, community development and investments in local service coordination and local social inclusion policy. Innovation programs can also be important instruments to experiment with harmonizing and simplifying complex acquisition and accountability regulations and in creating integrated budgets.

Comprehensive policy plan

As said, the policy measures suggested above will be most coherent and efficient when integrated in a comprehensive, cross-departmental, national policy plan. Basic to that plan should be the awareness, as propagated by key persons involved in this study, that social inclusion of persons with severe mental health problems is not utopian. It can be organized.

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The promotion and development of community care and community support for persons with severe mental health problems have been policy issues in many countries for some time now. Countries differ however in the range and the kind of national efforts they have made so far.

This report describes the results of an international comparison of the incentives of national policies and care funding systems on the development and implementation of comprehensive community support services for persons with severe mental health problems. These national incentives were studied from the perspective of three mental health care regions in Denmark, England and the Netherlands respectively. The report discusses differences and similarities in national policies and systems, in regional service provision and organization and in regional key persons' perspectives on the impact of national system characteristics and policy developments. It concludes with a series of suggestions for future national policies on community support and social inclusion.

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