

## Article

# Barriers and errors in the implementation of community psychiatry in Slovenia

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### ABSTRACT

**Background** Slovenian psychiatry is predominantly hospital based. A programme for the development of general community psychiatric services was proposed to improve access to and quality and comprehensiveness of psychiatric care according to the modern standards of delivery of psychiatric services.

**Aim** The aim of the paper is to present the programme for developing community services that was proposed to the Slovenian government, and to describe the barriers to its implementation that were encountered, as well as the errors made by the programme authors, that contributed to the rejection of the programme last year.

**Conclusions** There are historical, political, professional and service organisation characteristics that impede the development of community psychiatry in Slovenia. These are to be addressed through coordinated action involving primary care professionals, non-government organisations with service users and carers, the Health Insurance Agency and politicians involved in the planning of health services.

**Keywords:** community mental health teams, primary mental healthcare, public mental health indicators

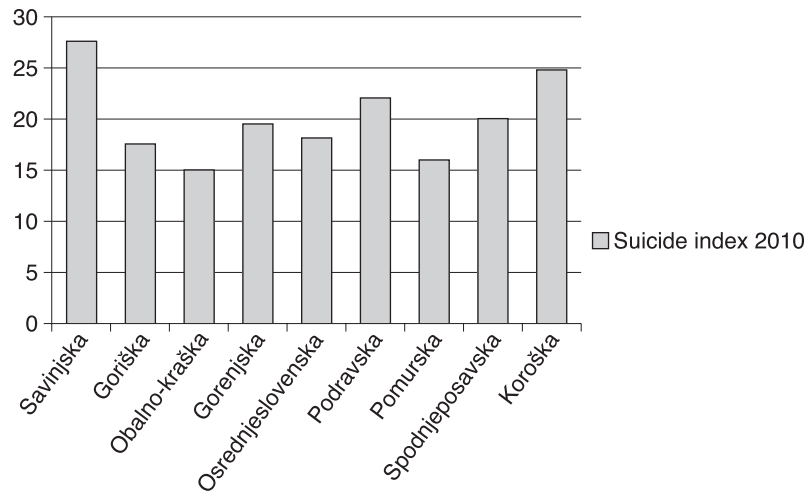
## Background

### The healthcare system

Slovenia is a central European country with a population of around 2 million people. Although healthcare is a universal right, access to some healthcare services is limited due to lack of providers or long waiting times (e.g. in psychiatry, waiting times for outpatient appointments are approximately 3 months). Healthcare services in primary care are mainly provided by primary healthcare centres, which are owned by the local community as well as by independent primary care providers. Doctors in primary care have a list of patients and act as gatekeepers to specialist services.<sup>1</sup>

### Health indicators

Studies conducted in Slovenia have shown that the prevalence of depression among family medicine attenders is lower than that in other European countries.<sup>2–5</sup> The average suicide index in EU according to EUROSTAT in 2009 was 10.3 deaths per 100 000 inhabitants, and 18.7 per 100 000 in Slovenia. This puts Slovenia among the five most vulnerable countries in Europe. The highest rates of suicidality occur in old age (21.9 per 100 000) and also in the 45–59 years age group, where the rate is 1.5 times higher than the European average.<sup>6</sup> The suicide index in Slovenia is unevenly distributed<sup>7</sup> (see Figure 1).



**Figure 1** Suicide index in Slovenia.<sup>16</sup> Source: Institute for Public Health (IPH) 2011.

The suicide rate is highest in regions that are distant from centres. These regions are also characterised by high rates of alcohol consumption and a lower gross domestic product (GDP), lower levels of education, high unemployment and poverty. Demographic indicators, using OECD methodology,<sup>8</sup> among them education, employment, GDP, housing, health status and occupational health, are worse in the East Slovenian regions and Koroška, which are also regions with a high suicide index. The suicide index is lowest in south-west Slovenia, with better demographic characteristics (e.g. in Goriška it is 15.00 per 100 000). In 2010, the regions at highest risk were in south and north-east Slovenia, with the following suicide rates: Celje, 27.8 per 100 000; Koroška, 24.8 per 100 000; Podravska, 22.0 per 100 000.

In 24.7–27.7% of cases, mental health disorders are the reason for acquiring complete disability status and pension in Slovenia (NMHP).

### Service provision

Mental health services in Slovenia are largely hospital based, organised in six psychiatric hospitals. The largest central psychiatric hospital provides treatment for all psychiatric patients in the catchment area, which has a population of 700 000, as well as subspecialist ambulatory and hospital treatment for adolescents, a department for treatment of eating disorders, psychotherapy and services for the geriatric population.<sup>9</sup> A forensic psychiatry department has only recently been established. Outpatient ambulatory care is attached to hospitals. Centres for social work offer counselling and care coordination. There are approximately 20 care coordinators for the whole

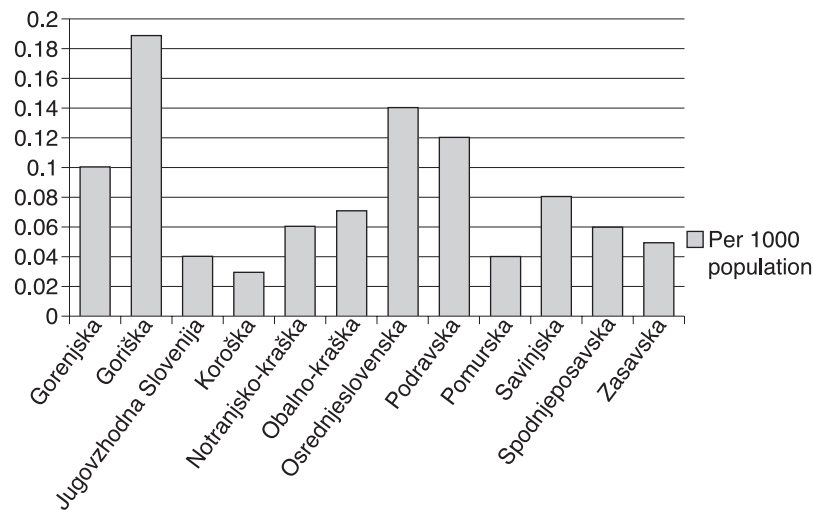
country. Non-government organisations (NGOs), which are funded predominantly from public social funds, provide vocational rehabilitation, coordination of care, day care centres and housing, as well as public health anti-stigma activities. NGOs are funded predominantly from public social funds.

The network of outpatient clinics was established by the 1970s, but was gradually dissolved after the healthcare reforms in the 1990s when Slovenia gained independence. During the development of community psychiatry the expertise of British community psychiatry *assertive community treatment (ACT)* was followed. By 2006, in three psychiatric hospitals in Slovenia, teams that included a psychiatrist, a social worker, an occupational therapist and three graduate nurses were established to follow up frequently readmitted patients, most commonly those with a diagnosis of schizophrenia in the community.<sup>10</sup> These teams did not manage to provide 24-hour cover, and they covered only frequently hospitalised patients. Nevertheless, the result of their work was that they managed to reduce hospitalisations by over 50% in selected groups of patients. The number of patients included reached almost 200 in 2012.

The provision of psychiatric services in Slovenia is uneven (see Figure 2).

The services are gathered in several centres, close to psychiatric hospitals. Other parts of the country which also tend to have more mental health needs (e.g. those with a higher suicide index) have very few psychiatric staff.

The numbers of appointments for psychiatric outpatient care, admissions to psychiatric hospitals and visits to general practitioners have not changed in the last few years.



**Figure 2** Slovenia: number of psychiatrists and psychiatric trainees per 1000 inhabitants and regions (all services). Source: Registration of health workers and health services, Institute for Public Health (IPH), September 2011.

Primary care research conducted in the country demonstrated that among general practitioners there are serious barriers to becoming involved in the treatment and prevention of mental health disorders.<sup>11,12</sup>

## The community psychiatric action plan

### Scope and purpose

New evidence suggests that medium-resource settings can develop general adult mental health services, namely outpatient clinics, community mental health teams (CMHTs), acute inpatient services, community residential care and work/occupation. High-resource settings, in addition to primary care and general adult mental health services, can also provide specialised services in these five categories.<sup>13</sup>

The rationale for the project was that the research evidence showed that a carefully conducted deinstitutionalisation process has been successful in producing favourable outcomes for long-term patients discharged into community care,<sup>14</sup> and that the study conducted in England and Wales demonstrates that provision of 24-hour crisis teams to provide intense support in the community was responsible for a fall in suicide rates of around 20%. The largest decreases in suicide rates appeared to be in those services with the most deprived catchment areas. Local policies on patients with a dual

diagnosis and multidisciplinary review after suicide were also associated with declining suicide rates.<sup>15</sup>

In Slovenia, CMHTs were proposed to become the basic building block for community mental health services to be provided for locally defined geographical catchment areas, prioritising adults with severe mental illness.<sup>14</sup> CMHTs should improve already existing support networks, including social welfare, health, housing and employment in NGOs and the private sector.<sup>16,17</sup>

The plan also supports the WHO/Wonca initiative to empower primary care workers to become more competent in the assessment, treatment and prevention of mental health disorders, with the support of a specialist workforce, and to improve access to mental healthcare ([www.who.int/mental\\_health/policy/Integratingmhintoprimarycare2008\\_lastversion.pdf](http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf)).

The process that was used followed the PDSA (plan, do, study, act) approach ([www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)).

### Planning

The professionals involved in mental health, as well as service users and carers gathered in NGOs, proposed that uneven access to psychiatric services and the quality of these should be addressed nationally, using European guidelines on suicide prevention<sup>18</sup> and research evidence on optimal service provision<sup>13</sup> as the methodology for developing the strategy and the action plan.

The *Plan* was to develop CMHTs in primary care settings in all 25 Slovenian regions by 2015, including coordination of existing services (treatment and prevention), consultation to GPs and social services, outreach, and crisis intervention following local and individual patients' needs. The plan was proposed to the Ministry of Health in 2011.

It was proposed that the project should be implemented first in regions where there is a high risk of suicide and other poor mental health indicators, these regions also being most deprived in terms of access to services.

## Implementation

The implementation of the plan (the *Do* phase) included the following:

- collecting local public health data and needs assessment as described in the WHO document *Human Resources and Training in Mental Health*<sup>19</sup>
- providing multidisciplinary education for community mental health workers. The draft educational proposal was prepared as part of the international Leonardo da Vinci programme with the University of Plymouth and the Slovenian NGO Sentprima, and was sent to university bodies in Slovenia for evaluation
- implementing the programme in four regions with around 50 000 inhabitants.

## Evaluation

The *Study* phase was to follow the *Do* action by the end of 2013. This phase would include the analysis of the project. We intended to conduct a process evaluation of service implementation, which would consist of assessment of the number of patients included, their characteristics, clinical, quality-of-life and functional indicators, number and length of hospitalisations, level of satisfaction, and their perception of discrimination in various areas of their life, using the discrimination and stigma scale (DISC).<sup>20</sup> The coordination of services might also influence some public health indicators (e.g. suicide rate), and these were to be monitored.

## ACT

On the basis of evaluation, the next step (*Act*) should follow in 2014 with a plan revised on the basis of the *Study* phase, which evaluated the functioning of the first four CMHT teams and their responses to patients' and communities' mental health needs.

Even though the proposal received positive reviews, it had not yet proceeded towards implementation. The whole planning process was prepared and generally also accepted by government bodies, albeit with much suspicion and uncertainty on the part of specialist care settings that wished to preserve and strengthen the already established institutional forms of care and treatment.

## Mistakes made

It is useful to look at the reasons for the long-term delay in establishing local psychiatric services in Slovenia. Two official reasons for opposing the plan were given: first, that there are already community staff working in hospitals, which should only enlarge their outreach, and secondly, that the programmes of hospital and general community psychiatry overlap.

Before we examine these two reasons, it is necessary to identify other barriers that were not explicitly stated. These overlap with those defined by Saraceno *et al*,<sup>21</sup> and may be summarised as insufficient funding, centralisation of mental health resources in cities and major institutions, lack of integration with primary care (primarily due to lack of primary care resources), limited training of mental health workers in the community, lack of mental health leaders with an understanding of public mental health needs, and fragmentation among mental health services.<sup>21</sup>

Slovenia has historically relied upon psychiatric hospitals, and all other service provision is considered very cautiously. There are historical reasons for this attitude, for example, rapid and very poorly planned deinstitutionalisation during the Second World War and afterwards. Historically, the development of psychiatric services in Slovenia was strongly influenced by a reluctance to accept the 'Trieste deinstitutionalisation' in neighbouring Italy.

The responsibilities among sectors are fragmented. In Slovenia each system of care develops its own network of services. Community care with outreach for people with severe mental disorders is developed in psychiatric hospitals, in centres for social work and in NGOs. There is some overlap between these services and often they are not coordinated with each other. A programme that would require these services to work together was obviously regarded as a challenge to the established routines.

The professional establishment in secondary care (psychiatric hospitals) was against new roles for non-specialists and non-medical staff. Inadequate communication about the new programme to hospital staff and management, and their non-involvement

in the development of the project, are two of the mistakes acknowledged with hindsight by the project leaders. The small size of the psychiatric establishment in Slovenia (the vast majority of psychiatrists work in hospitals, and there is an obvious lack of psychiatrists in Slovenia, according to EUROSTAT data) makes this communication more difficult. Overcrowding of existing hospital services makes the shift of resources seem completely unjustified. On the other hand, primary care as a whole, and general practice in particular, are facing a problem with regard to high workload, and are therefore reluctant to take on additional responsibilities.

Community mental health services emphasise the importance of treating people and enabling them to live in the community in a way that maintains their connection with their families, friends, work and community. In this process, community care acknowledges and supports the individual's goals and strengths to further their recovery in their own community.<sup>16</sup> A fundamental principle supporting these values is the notion that people have equitable access to services in their own locality in as unrestrictive an environment as possible.

The lack of training in community interventions in many European countries is obvious. For the reasons cited earlier, training in community care is not in accordance with traditional education in psychiatric hospitals. The proposal with regard to training for the project in the community was strongly rejected by the established psychiatric educational board in Slovenia, and the project leaders acknowledge that there is a need to more carefully design and negotiate educational proposals with these bodies.

The precise scope and purpose of community psychiatry was not made sufficiently clear. There were rumours, for example, that NGOs wanted to take over psychiatry, that centres for social work are doing so, and that the law does not allow the practice of community psychiatry.

One of the greatest problems was caused by relying on the UK model of community psychiatry. Almost every hospital psychiatric team in Slovenia was trained in one community centre in the UK, which proposed its cooperation and education of community teams. This is a well-financed community service with a whole range of services for people with mental disorders, including early intervention, ACT, crisis intervention, geriatric services, etc., that it has been possible to establish within the well-developed and well-financed UK model of care. The professionals who came from this service strongly opposed general CMHTs because they themselves worked in hospitals, and could not address general mental health needs regionally.

However, the biggest mistake in the view of the project leaders is insufficient coordination with existing services at the primary and secondary care level. With lack of resources, strong political determination to shift the majority of psychiatric care and prevention to the primary care level is needed. Lack of clear political decision making has led to the absence of resources for planning, evaluation and education with regard to community care.

## Conclusion

In theory, the benefits of introducing generic, community-based multidisciplinary teams are well documented and researched. Provision of services in this way increases user satisfaction, increases the number of met needs and improves adherence to treatment.<sup>17</sup> This kind of approach gives greater hope for social integration, human rights protection, comorbidity treatment, reduction of stigma, and better access to treatment and rehabilitation. The community-based multidisciplinary approach is now the norm for delivering high-quality mental health services for the benefit of the population. In practice, factors that have little to do with science have a major impact on policy decision making. The main lesson that has been learned is that not enough care was taken to consider other factors that play a role in policy making. A shift of resources from the primary level of care is only possible if there is clear political determination to achieve this.

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