Challenges for psychiatry: delivering the Mental Health Declaration for Europe

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Mental health care is in the process of transformation across the European Region, due to a combination of recognition of disease burden, poor treatment conditions and demand from clinicians and the public. This transformation affects the scope of mental health, increasingly including promotion and prevention, and the structure and process of care, shifting to community based delivery. Many psychiatrists are in leadership positions, able to influence policies and strategies. But their work is also seriously affected by the consequences of these policies. New roles and responsibilities of all members of a multi-disciplinary team need to be planned, and education and training have to be designed to prepare professionals to deal with expectations and demands. Psychiatrists face major challenges, since their complex roles are affected in multiple ways by the psychiatric and general health system. Some of these challenges can be addressed by the psychiatric profession and their partners, including patient and family organizations; others require wide ranging changes in attitude and system design.

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The last few years have seen very active policy developments transforming mental health care in all parts of the European Region. Gradually, over the course of the last 30 years, principles of community based services have been introduced. The World Health Report 2001 (1) stated the principles, and the Mental Health Declaration for Europe (Helsinki Declaration) (2) placed them in a European context. Many countries in the European Region of the World Health Organization (WHO) are now actively drafting and implementing new mental health policies and legislation, and developing community based services.

These developments have been driven by several factors, all relevant to the countries in the Region, if of varying relative importance. All governments are concerned about the high and growing burden of mental disorders (3), the suffering of individuals and the cost to society, both in social and economic terms. More specifically, there is a growing awareness of the public health aspects of mental health, including promotion and prevention, which implies a government responsibility for action, rather than delegating action to the medical profession. An example is banning of toxic substances by law in order to prevent suicide.

Many drivers are not top down, dictated by governments, but are bottom up, most effectively so when demanded by a coalition of the public and professionals. The gradual reduction of stigma related to common mental disorders such as anxiety and depression has resulted in an increasing demand of treatment. The empowerment of the population in many countries and a growing knowledge of the availability and effectiveness of new treatments, such as the iconic status of drugs such as Prozac, has put great pressure on governments and professionals alike to supply adequate capacity for care, provided on terms desired by users and carers. People no longer accept degrading forms of care for their friends or relatives, whether neglect in institutions or long waiting lists, and demand access to information. There has been a growing emphasis on human rights, supported by the Convention for the Protection of Human Rights (4).

Demonstrably, the influence of professionals has been crucial, mostly psychiatrists who acted as champions of change, such as Pinel in France in the 19th century and Basaglia in Italy in the 20th. They offered visions of new models of humane and effective care, revolutionary for their times, replacing inadequate and abusive traditional services. Their real achievement was the ability to inspire politicians to champion these visions and persuade colleagues to implement them, thus enabling real and sustainable change.

However, charismatic leaders and a supportive public are essential, but not sufficient. It has become clear that mental health reform is not a cheap option, and it is therefore unlikely to be coincidence that comprehensive reforms have taken place in countries that could afford increased public expenditure and investment in health, allowing the development of new services and growing numbers of staff.

An important fact to bear in mind is that few conditions are identical at any point in time across the 52 member states of WHO-EURO, and priorities are therefore very different, ranging from subtle implications of social exclusion in employment settings to preoccupations with obtaining a meal in asylums. The European Region of WHO is very diverse, comprising some of the richest countries in the world, especially the members of the old European Union, as well as countries with high levels of poverty and deprivation. On average, the mental health budget is 5.6% of the total health budget, but varies from less than 1% to about 12% (5). Similarly varied are rates of psychiatrists, nurses and other staff groups.

Despite the evidence, if not overall agreement, that community based care is advantageous for most people with mental health problems, there are a number of challenges that need facing. First, we are living in times when economic pressures have introduced greater scrutiny of cost effectiveness in psychiatry, both at the level of service

models and interventions. Second, a unique challenge is the public perception of mental illness and in particular schizophrenia as a risk category, and the demand that psychiatry safeguards society by locking away securely anyone who could pose a potential risk. Third, mental health care is experiencing recruitment difficulties, when specialization and decentralization demand a fast growing number of staff. A factor negatively affecting all these challenges is stigma and discrimination.

Taking into account these factors, differences and challenges, mental health strategy is converging in a remarkable fashion across Europe. This is illustrated by the consensus achieved at the WHO European Ministerial Conference on Mental Health in Helsinki, where the representatives of the 52 member states endorsed the Mental Health Declaration and Action Plan for Europe (2). The Declaration formulates the scope and priorities for mental health care in the next decade and the actions and responsibilities member states and the WHO Regional Office for Europe commit themselves to in order to reduce the burden and suffering caused by mental health problems.

The Declaration was signed on behalf of ministers of health and was endorsed by a unique range of non-governmental organizations, including the WPA and other professional bodies as well as patients' and carers' organizations. The Declaration and Action Plan offer a great opportunity for psychiatry and psychiatrists to advance the claim that mental health is a priority for governments, and that it is timely to not only design and implement strategies, but also to support them financially and legally. Psychiatrists are central to any progress, since in many countries they occupy roles of responsibility such as advising on strategy, drafting action plans and leading the implementation and delivery of care.

THE HELSINKI DECLARATION

The Helsinki Declaration details 12 areas of action and the resulting responsibilities for the ministries of health in member states. An area that required attention at the drafting stage was the scope of mental health care. It proved necessary, considering the expansion of responsibilities of mental health well beyond the traditional roles of psychiatry in hospitals and outpatient settings, to clarify boundaries and to determine priorities. It is within this scope and its priorities that the challenges to be met by psychiatry are presented.

Scope

A key sentence in the Declaration is that "policy and services are striving to achieve social inclusion and equity, taking a comprehensive perspective of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and people with mental health problems". This means that the scope of mental health care has shifted from a narrow focus on the treatment of people with severe mental illness to cover also population interventions that could increase the well-being of vulnerable groups. Mental health promotion and prevention have gained a prominent position in the thinking of governments. However, it is acknowledged that this requires a careful balance, taking into account the needs of target groups and the effectiveness and efficiency of actions. Implications are that any policy has to be judged on its potential benefits at population level, but effectiveness, cost, desirability and fairness have to be taken into account, i.e. whether policies have the potential to be of most benefit to those with greatest needs.

Priorities

The priorities set the agenda for action for health ministries over the next decade (Table 1).

These priorities are specified in the 12 action points of the Declaration. The Action Plan, endorsed in the Declaration, details the desirable steps to implement the Declaration. The Declaration and Action Plan propose a model of mental health activities that places mental health at the heart of policy making, emphasizing well-being, human dignity, recovery and social inclusion. This implies partnerships between health and other government sectors. But such a model is only feasible if there is a recognition and commitment by governments not just of drafting of policies, but also of the long-term need for investment in modern models of interventions, a sufficient and competent workforce, enabling legislation, finance and evaluation.

CHALLENGES FOR PSYCHIATRY

The Declaration offers a powerful opportunity for change, but there are a number of challenges, starting with the very different context of countries. Despite the differences, in every country services are in transition, and the direction of travel and some of the essential principles of change are remarkably similar, including the challenges and opportunities for psychiatrists.

Table 1 Priorities of the Helsinki Declaration

1. Foster awareness of the importance of mental well-being
2. Collectively tackle stigma, discrimination and inequality and empower and support people with mental health problems and their families to be actively engaged in this process
3. Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery
4. Address the need for a competent workforce, effective in all these areas
5. Recognise the experience and knowledge of service users and carers as an important basis for planning and developing services

The broadening scope and the shift to community based mental health services introduce greater levels of complexity, affecting the role of psychiatrists. Psychiatry now has to consider its role in areas such as promotion and social inclusion. Psychiatrists will work in more settings, with more staff groups. Planning and management will take a more central place, and accountability is likely to become more transparent.

However, psychiatrists are not passive recipients in this process of designing, implementing and delivering mental health activities. They possess a unique expertise, and occupy leading positions in most countries, functioning as advisers to governments and chairing drafting groups that are responsible for the production of policies and action plans. There are countries where such groups comprise only psychiatrists. They have therefore a unique opportunity to shape the process of reform in the best interest of patients, families and carers, the public and staff.

The number of countries that are developing and implementing policies is remarkably high. Similarities between strategies are noticeable, including some of the challenges emerging in many countries. There is also considerable duplication of effort. Although there is a fair point to be made that each country should be allowed to develop its own strategies based on its own unique circumstances, there is also a point to be made about inefficiencies of reinventing the wheel and value of learning from other people's successes and failures, especially at a time when governments are committed following the Ministerial Conference in Helsinki. The next step should be a sharing of experiences by psychiatrists and other experts of implementing strategies, since those steps are likely to include some similar challenges.

Service model

The model of care drives practice, and many challenges can be predicted from the planned structures and processes. An example is the role of community mental health centres and their remit to prevent admission or to rehabilitate people with long-term problems, and their authority in respect of hospital admissions or discharges. Another is the diagnosis and treatment responsibility of primary care, very underdeveloped in many countries. Each strategic decision for one part of the system will have consequences, often also unintended ones, on other parts of the system. It is therefore crucial that psychiatrists are closely involved in strategic planning, and have the expertise to influence this process, but these examples also suggest that other professions also need to have ownership.

Clinical roles and responsibilities

Community based services require differences in attitude, knowledge and skills from traditional forms of care. For psychiatrists to be effective, new roles need to be adopted, often very complex since they require a good grasp of the needs of patients in multiple settings and the ability to work intensively with staff from a variety of backgrounds. These different aspects of the psychiatrist's role raise a variety of challenges not very well addressed in many strategies:

Therapeutic role

Although the essential role of most psychiatrists will remain their therapeutic work with patients, the type of problems presented by people in a community setting and their expectations of psychiatrists' activities will be radically different. No longer is a detached medical role sufficient. Patients will also want personal attention for their problems living in a social environment. This raises the challenge of what this means for the role of the psychiatrist. Questions to be addressed are any desirable shifts in: exclusive responsibility of psychiatrists based on special expertise, such as diagnosis and prescribing; shared roles in areas such as follow-up, co-ordination and providing information; and common activities which can be done equally well or better by other and lower paid staff groups with suitable skills such as housing assessments and support with basic social activities.

Membership of multi-disciplinary team

Implementation of community based practice requires team work, offering in combination a variety of skills. How diverse individuals within a team can function most effectively together, working jointly comprehensively but individually efficiently, requires careful consideration of roles, responsibilities and training.

Functioning in diverse roles and settings

Many psychiatrists function in a diversity of clinical roles, spending a proportion of their time in hospital, community teams, management and other settings. This raises new challenges about responsibilities and skills. Time management, ability to delegate but also role clarity are essential requirements if psychiatrists are to operate effectively.

Broadening societal scope of psychiatry

The shift in scope from psychiatric care for persons with severe mental health problems to offer mental health activities for all persons at risk of mental health problems has been accompanied by a broadening of responsibilities of mental health professionals, now expected to be also active in mental health promotion and prevention. At the other

end of the scale, greater emphasis is being placed on the balance between human rights of the individual and the avoidance of any risk to society. This results in a very complex set of challenges driven by contradictory values and yet to be clarified implications for practice, including the capacity and role of psychiatrists and other professionals.

Partnership working

The needs of patients and families in modern mental health practice are beyond the capacity of a single sector, and partnership working is increasingly accepted as essential. This includes health and social care agencies, employment, benefit, housing and education agencies. Such an interactive way of working introduces new challenges about boundaries, leadership and accountability, not only at practice level, but also at legislative level, since many ministries are responsible. Who decides priorities, and who is responsible for continuity of care or poor quality care? What is the role and where is the position, within these spider webs, of psychiatrists?

Leadership

Complex service models require strong and transparent leadership, whether of interventions, teams, organizations or systems. The leadership of strategic change processes, service delivery and staff is essential for good and efficient care delivery, but this will rarely be the responsibility of the same person. At each level, quality of implementation and delivery is often associated with a competent identifiable individual. A distinction needs to be made between leadership and executive management. Traditionally psychiatrists have been in charge of mental hospitals, supported by administrators. In community based services, lines of authority and management are less straightforward and therefore more challenging, and different leadership roles and leaders can be required even within one team. Poor functioning of services can often be attributed to role confusion, and training of individuals and teams in these skills is a key challenge. The question that constantly re-emerges is the optimal leadership role of psychiatrists in modern mental health services, and the interface between such leadership, service management and clinical work.

Information systems

The complexity of community care systems can result in the unintentional lack of care or duplication of services. For psychiatrists to work effectively, they require information to plan, act and evaluate. It is an obvious statement that systems and processes need to be introduced that assist efficient clinical work, budget control, planning and inspection. However, in reality such systems are highly complex and costly. Information functions all require inputs and analysis. There is too often a tension between expectations of clinicians and managers for minimum input by themselves but maximum information provided by the system. Designers do not always take into account time requirements and clinical reality, and expectations of validity can be extremely optimistic. Considering the importance of information for clinical practice, management and accountability, involvement of clinicians in the design of systems and staff training is rarely adequate.

Research

Research is essential to both inspire and validate innovations in care, but it needs careful interpretation. There are too many examples of ignorance of well established evidence or inappropriate acceptance of irrelevant and/or bad research, and psychiatrists need to be able to assess the quality and potential local relevance and inform decision makers. In turn, the introduction of new service models and interventions locally needs to be subject to audit and evaluation in order to judge benefits and need for adaptation. It is yet uncertain to what extent research is a specialist role or should be a core part of psychiatric expertise.

Competence

A key challenge, and one of the priorities in the Declaration, is the competence of the workforce. The transformation of services and practice demands changes in attitudes, training and education. This means a reconsideration of competency development, producing psychiatrists fit for purpose. The role of psychiatrists has to be considered in conjunction with other professional groups, which can be a major struggle due to different agencies responsible for the development of curricula and the delivery of training, both within and across staff groups. Particularly numbers and competencies of nurses and social workers are very poorly developed in many countries. The international opening of borders for practice also requires quality standards that are uniform across countries, such as competence in evidence-based psychotherapies. Organizations such as the WPA and the European Union of Medical Specialists (UEMS) will have a major role to play. A related and complex challenge is the migration of trained staff in some countries, creating disincentives to train mental health staff in the first place.

Career development

The system of mental health care indicated suggests a

growing number of roles for psychiatrists. No single person can acquire all the expertise to be a service leader, clinical expert in diverse specialist areas, researcher or trainer. The variety and constantly changing roles of psychiatrists in mental health care suggest that basic training can only prepare for the fundamentals, and that further specialization is necessary to function in the multiple roles psychiatrists can take on. This could create a stimulating opportunity for continuous education and further specialization linked to career stages on the basis of experience, interest and aptitude.

Status and funding

If psychiatry is to function effectively, it needs to be attractive as a specialty within medicine. If effective community services are to be developed, they should have a status at least comparable to hospital care. Neither is generally the case. The status of psychiatric services is mostly very low. Presently mental health funding is very low in many countries, not allowing the development of modern service delivery (5). There are also often disincentives against the delivery of community based services such as reimbursements based on hospital bed days and limited funding for community treatments. Most psychiatrists are comparatively poor earners due to reimbursement rates discriminating against mental illness. Examples are reliance on co-payments by poor patients suffering from severe mental health problems or exclusion of psychotherapies. Some countries also offer lower salaries to staff working in the community as compared to hospitals.

Legislation

Mental health legislation needs to create a value base for positive mental health care by establishing a balance between the rights to autonomy of people with mental health problems and their protection on behalf of society. Legislation also needs to provide a framework for effective practice, again balancing the clinical judgment of clinicians and the rights of patients and/or their relatives and/or society. The protection of clinicians also needs to be safeguarded. Although these balances will never be totally satisfactory to all interested parties, presently legislation in some countries is dysfunctional, hindering service innovation. There are also some examples where legislation is so innovative that it is out of touch with reality, and therefore ignored, creating a lack of respect for mental health and disinterest in modern practice.

Stigma

The negative consequences of stigma affect every part of mental health and much can be explained by its impact. Stigma leads to discrimination against patients and relatives. It causes the marginalization of psychiatry, and demoralizes the workforce. The intake of medical students into psychiatric training is low and declining in many countries at a time when more psychiatrists are needed. Psychiatric units are frequently placed in the most deprived part of general hospitals, if tolerated at all. This has a major negative impact on the status and effectiveness of psychiatrists, and is probably the key challenge to address to turn around the crisis faced by psychiatry in some countries.

CONCLUSION

The consensus achieved by the Helsinki Declaration, accepted by all 52 member states of WHO-EURO, offers a once in a generation opportunity to drive reform, and is already leading to considerable activity in areas of policy and practice. The strategies and legislation that are emerging across the Region endorse community based services. However, they also expose the challenges that have to be addressed for services to serve effectively and efficiently the needs of patients, families and staff. Psychiatrists are placed in leading positions and own much of the required expertise to address these challenges in many countries. There are opportunities to learn from experiences of research, policy and practice in diverse countries. It is an opportunity for professional organizations such as the WPA and the UEMS, in partnership with intergovernmental agencies such as the WHO, to harness the available knowledge and expertise to take on these challenges. The next decade has the potential to be memorable for mental health.

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