World Health Organization
REGIONAL OFFICE FOR Europe

WHO Mission to assess the progress of the mental health reforms in Portugal
WHO Regional Office for Europe
16-18 February 2011

Introduction

This assessment mission was conducted under the terms of the partnership agreement between the Ministry of Health of Portugal and the WHO Regional Office for Europe. The objectives were agreed with Professor José Miguel Caldas Almeida, Implementation Coordinator of the mental health plan, as:

1. Completing an assessment of the present status of mental health services in Portugal;
2. Identifying the main challenges in implementing the National Mental Health Plan;
3. Based on the above making key recommendations to support future progress.

Participants in the mission were:
Dr. Matt Muijen, Programme Manager Mental Health and Neuro-Degenerative diseases, WHO Regional Office for Europe, Copenhagen.
Dr. Angelo Fioritti, Director, Mental Health and Substance Abuse Department, AUSL Bologna, Bologna, Italy.
Dr. Manuel Gomez-Beneyto, Scientific Coordinator of the Spanish National Strategy on Mental Health.
Dr. Andrew McCulloch, Chief Executive, Mental Health Foundation, London, UK.

Programme

The mission took place from 16-18 February 2011 (programme attached). During the visit a range of community services and hospitals was visited. The policy and its' implementation was discussed with the members of the national implementation team. We are very grateful for the time and effort committed by the staff of the services, who produced excellent and informative presentations.

Mental Health Policy and Legislation

Portugal has experienced 2 cycles of reform in modern times. The first lasted from 1963 (law 2118) until 1990, introducing primary care liaison and district mental health centres. This was followed between 1990 and 1995 by a period of retrenchment during which the role of the psychiatric hospitals was strengthened and mental health centres were abolished.

The present reform phase was formalised by the mental health law that was passed in 1998 (Law 35/98 and Decree Law 36/99) after a period of national consultation. This law established rights of service users and regulated compulsory admissions. It introduced the principles of

community based services and psycho-social rehabilitation, to be provided by multi-disciplinary teams. In patient care, when required, should preferentially be provided in District general hospitals.

Progress was limited following the introduction of the legislation, and in 2006 the government created a National Mental Health Plan Committee which produced a National Plan the following year. The Plan is ambitious and comprehensive and is written in the spirit of modern and international principles, including both the WHO 2001 Global Mental Health Report and the Helsinki European Declaration and Action Plan 2005.

The National Plan supports a national network of local mental health services that are community based and supported by beds in District General Hospitals and are responsible for the local population. Additionally it proposes some regional services for specialized care such as eating disorders and forensic care.

Special emphasis is given in the Plan to the need for cooperation across sectors. This is particularly essential for the effective functioning of two key areas. Firstly, primary care should be supported by mental health services to enable family doctors to identify, diagnose and treat the large number of patients with common mental health problems such as anxiety and depression, for which the specialist mental health system lacks the capacity.

Secondly, residential and vocational services need to be developed by the responsible local authorities. Without these, deinstitutionalization is not possible due to the absence of opportunities for transfer from hospital beds and the provision of ongoing support in community settings for patients with chronic conditions as well as for new patients with severe mental health problems at risk of becoming institutionalized without intensive community support. The consequences of the absence of both these forms of cooperation will be referred to later in this report.

Finally, the National Mental Health Plan refers to the need to develop mental health services for vulnerable groups that require specialist interventions. These are child and adolescent services and old age services. Both rely heavily for their adequate functioning on partnerships with other sectors.

Mental Health Services

During the mission we visited several psychiatric units of general hospitals, psychiatric hospitals and community mental health centres. This report does not aim to give a detailed description of each, but makes some general observations which may support the successful implementation of the mental health plan.

Psychiatric Hospitals

In 2005 six large mental hospitals were active, operating a total of 1716 beds, half the number active in 1970. In 2006, in Lisbon alone, the Psychiatric Hospital Centre (LPHC) ran 835 beds in the two hospitals Julio de Matos and Miguel Bombarda. At the end of 2009, the LPHC operated 530 beds, and the figure has further decreased since then due to continuing reduction of beds in the Miguel Bombarda Hospital which is due for closure by the end of March 2011 with the transfer of the last 27 long term patients. This closure will happen one year ahead of the schedule set out in the Plan. The activity of Julio de Matos hospital has also significantly decreased, from

a total of 758 beds in 2006 to the current figure of 491. This number comprises 166 acute beds, 196 for long term patients, 97 for rehabilitation and 32 for forensic patients.

The 35% reduction in bed numbers has been accompanied by a reduction in length of stay of *acute* patients from 37 to 16 days (57%), indicating improved efficiency and therefore a net increase in the number of treatment episodes. The number of patients with a stay of over a year had decreased by 50% (393 to 185), but patients with a stay of between 6 and 12 months had increased by about 50% (40 to 62). Since the number of long term residents discharged is reducing, this raises the question of whether a new cohort of long stay patients is developing.

The conditions in the Julio de Matos hospital were basic but reasonable. Staffing levels were low by EU standards (see below). The funding system of the psychiatric hospitals, apparently largely based on historical allocations, is not linked to activity and efficiency. This will be addressed later.

District General Hospital (DGH) Units

Psychiatric services in DGHs are managed by the General Hospital Administrations (EPE – Entitade Pùblica Empresarial). These Administrations must provide in- and outpatient mental health services for a geographically defined catchment area. The general administration determines the mental health budget. According to the law], mental health services should have a dedicated budget, but in practice this has not been implemented. In 2005, thirty Local Mental Health Services were operating and 24 of them had an inpatient unit, with a total of 1,010 beds.

The 2 DGHs visited were different in structure, one stand alone, the other integrated within the general hospital building. Both were of a good structural condition, with motivated staff. Numbers, however, were low - typically 3 nurses on duty for a ward of 24 patients, and their ability to provide therapeutic care must be questioned.

Within the scope of these DGH mental health services, there was a high reliance on the Emergency Room (ER). One of the hospitals, where the ER was open weekdays 8am to 8pm, received 85% of its admissions through the ER, the large majority on Monday morning. Most of these admissions had a diagnosis of schizophrenia, many with co-morbidities. About 60% of the readmissions had not been in contact with psychiatric services.

Each of the inpatient units had remarkably similar statistics for length of stay. While mean length of stay had fallen since 2000, it had increased in both units from 15 to 20 days between 2008 and 2010. The reason given was the inability to discharge a relatively small number of patients with high levels of need, who could not be passed on to long stay placements due to lack of availability.

Community services

The Mental Health Plan proposes the development of Community Adult Mental Health Centres (CMHCs) across the nation, staffed and funded by the progressive downsizing and closure of the large scale psychiatric institutions. In 2005 there were 30 CMHCs, mostly located in the district capital. The MH Plan provides a framework and a timetable for the development of CMHCs across the country which should be completed in 2016. This programme appears to be proceeding at a lower speed than the deinstitutionalization programmes and this is creates a potential risk of a gap in services.

Each of the hospital units we visited was linked to several CMHCs, but we are aware this is not everywhere the case.

Facilities and programmes we visited were located in suitable settings in the community, either in stand alone premises or in polyclinics with primary care physicians and other specialties. Teams are typically responsible for comprehensive psychiatric community services for 80-100,000 people. They comprise 6 to 10 people, typically 2 psychiatrists, 2 nurses, 1 psychologist and 1 social worker. Their activities are mainly clinical. Staff seems to be well prepared, highly motivated and skilled.

Comparing Portugal with other European countries, the present level of mental health service utilization by the adult population suffering from mental disorders is low (1.7% vs 5-8%) and the use of primary care facilities is relatively high (7% vs 11%). Therefore the demand for specialized services is likely to increase in the near future. In fact the number of people using mental health services has increased already by 8% in the last 5 years.

Some data illustrate this point. On the basis of epidemiological studies, it can be assumed that 8% of the population requires mental health support for any condition annually and 2% of the population suffer from major psychiatric problems. For 80,000 people, this would mean respectively 6400 and 1,600 persons. A team we visited had seen 348 new patients in 2010, mostly with anxiety and depression. About 500 cases were active, and 1300 were in the system. This implies a major treatment gap, but also very high pressure on the small teams. There is a risk of demand exceeding the capacity of the system to respond, leading to medicalization, staff burn out, excess demand and unmet need, and deterioration in the quality of care.

Considering the discrepancy between small workforce supply and high patient demand, teams are not able to provide multidisciplinary psychosocial care. Outreach activity is limited to emergency intervention. Rehabilitation interventions in the community are not possible.

It was noticeable that most community services relied for their initial funding on the targeted monies for pilot projects from lottery money, allocated by the Planning Unit.

In combination, community services in Portugal face a number of challenges:

1) Only limited number of CMHCs are active,
2) Those existing are understaffed,
3) They are at risk of being overwhelmed by referrals from primary care of persons with anxiety and depression,
4) People with severe and/or chronic problems are at risk of being ignored or undertreated,
5) They provide mostly medical and some psychological activities,
6) Funding is unstable, and sustainability an issue. Financial disincentives will be discussed below.

Placements and Continuing Care (CCI)

The gradual deinstitutionalization of people with severe and long-term psychiatric conditions requires coordination with residential facilities and continuing community support if breakdowns and readmissions are to be prevented. Since the community facilities required by disabled persons are often fragmented across several agencies, coordination and leadership is crucial.

The reduction of long stay beds in hospitals increases the reliance on community placements for people with long term support needs. The earlier observation that acute beds are being blocked

due to the inability to transfer patients is a warning sign that the care pathway is fragile and that the system could become silted up.

The role and responsibilities of the social sector, including the religious orders, offer unique opportunities and challenges. Their capacity seems to have remained fairly stable, and they have skills, resources and volunteers. They also receive a limited subsidy. Accountability is not transparent, although a consultation process with local mental health services is required to select people for care. The formality of this process and the responsibility for the eventual selection have not been explored within the scope of this mission, but are very important.

Great care should be given to prevent institutionalization in the community, i.e. people moving from places in a long stay hospital to social institutions. Quality control is beyond the scope of this review, however, there are clearly risks in this area especially in the absence of a national quality standards agency. At a time of shrinking capacity of the public system to provide long term placements, and when new resources and investments are unlikely to become available, the ability of and interfaces with, the social sector is essential for the functioning of the system as a whole, maximizing the availability and suitability of residential placements in the community.

Residential placements need to be supported by mental health services in partnership with other agencies. Law 8/2010 aims to realize the social inclusion of persons with long term mental health problems by the establishment of multi-disciplinary teams and services coordinated across agencies. These services cover home support teams, socio-occupational units and residential facilities offering care and support in response to the needs of the service users. Coordination will be at national, regional and local level and financing according to the decree will be provided by the Ministries of Labour and Social Solidarity and Health. At a national level, a National Mental Health Council is proposed and Regional and local bodies are also proposed. Local responsibilities including coordination and budget authority by the director of the local mental health department are identified. An outstanding challenge is authority and co-financing mechanisms across sectors such as social services and housing, a challenge in every mental health system. The Decree-Law 8/2010 has great potential to address some of the most prominent issues. At the moment, the provision of both residences and support services for long term adult patients, for patients with special needs and for children and adolescents, seems to be very low for the needs of the population.

Human Resources

The population ratio of the mental health workforce (at 25 per 100,000) is at the bottom end of the range according to European standards, requiring careful consideration of how to achieve an optimal balance between staff employed in community services and in hospitals. An example of the challenge is one area of Lisbon with a population of 340,000 people that is served by 8 psychiatrists and 21 nurses for all types of service.

The situation in rural areas is likely to be even more challenging. The very uneven geographic and institutional distribution of the workforce creates inequity and seriously interferes with accessibility, as shown by the large variability in rates of human resources between hospitals (from 6.6 to 47.4 staff per 100,000), in service use (from 2.4% in the North Region to 1.2% in Algarve in 2010) and changes in service use across regions (from +19% in centre Region to -14% in Algarve from 2005 to 2010). This issue calls for special attention and the more equitable distribution of human resources.

The multidisciplinary mix within the workforce is not suitable for caring for people with severe mental disorders living in the community. While the proportion of psychiatrists is relatively adequate (6.7 per 100,000), ignoring their distribution and the proportion working in private practice, that of mental health nursing (2.5 per100,000) and psychologists (2.5 per 100,000) are extremely low. The case of mental health nursing is aggravated by the fact that the large majority of nurses are working in hospitals, and many are not trained in mental health. This may explain why in Portugal compared with other European countries, nurses are rarely consulted because elsewhere they form the backbone of the workforce across all settings.

Given the predominant biomedical culture and the scarce availability of community mental health teams for training workers in community mental health, the National Mental health Committee launched a programme of training courses to promote the development of skills and competencies relevant to community work. This strategy was appropriate as an initial move but in the long run this system needs to be taken up by the National training agency.

A significant concern is the present lack of experience of the workforce of work in community settings. There are no expectations yet for training in competencies for community mental health work such as an effective mandatory period of rotation in the national training programme for psychiatrists. The same should apply to psychology and nurse training.

The greater acceptance of mental health care by the community will increase the pressure on primary care to provide brief and effective interventions. Family doctors will be tempted to address this by prescribing of antidepressants and anxiolytics, which can be costly. Equally effective are brief evidence-based psychosocial interventions for anxiety and minor depressive disorders, which should be incorporated into the training programme of staff working in primary care.

Finance and management systems

Presently different funding systems exist for DGH based services and the traditional mental hospitals.

Mental health services within general hospital provider units are resourced by senior management by allocation of staff and facilities. Mental health budgets are not ringfenced or delegated. This system discourages the development of community based services.

Mental hospitals have a different funding system, receiving a block grant from the Ministry of health on the basis of historical bed numbers. The disadvantage of this system is that there are no incentives for efficiency, and indeed there are considerable perverse incentives against increasing activity.

In combination planning is difficult and rational management and planning virtually impossible.

The current situation for mental health services within District general Hospitals is that mental health budgets are constructed based on allocations reflecting service utilisation for a narrowly defined set of services (entirely medically led): inpatient care; medical outpatients; day hospital sessions; emergencies; and home care. There are penalties for straying outside a target band of activity levels. Within this group, medical outpatients are relatively well resourced and are the most profitable part of the service, home care receives a low reimbursement and interventions in the community by non-medical staff are not funded. Incentives for financial investment by management are obvious, and are in the opposite direction of the desired change.

Perverse incentives are common internationally in mental health where bureaucratic structures work against policy and rational management. However, they seem to be quite marked in the Portuguese system. There is a range of reforms that have been used internationally to reduce perverse incentives and improve the rational management of mental health services including restructuring providers, reform of commissioning and developing the financial management system e.g. by introducing budgetary control with cost centres, making tariff adjustments using DRGs or payment by results etc. The latter seems to have the most potential in Portugal although the other two areas are worth considering briefly.

Autonomous mental health provider units have been found helpful in many countries in giving mental health more status and allowing services to develop. Currently all medical specialties in Portugal exist within single general hospital based provider units. Whilst it is unrealistic to suggest radical change to provide structures just to suit mental health, a gradual development of more managerial autonomy within the mental health units of general hospitals would be helpful coupled with the development of a local/regional leadership role mentioned above and in line with Decree 8/2010.

Commissioning of mental health services at present seems to be based only upon allocating resources based on a simple tariff. Expert mental health commissioning functions are rare internationally and probably beyond Portugal's capacity and resources at present. It may be better to generate change via modest but important changes to the tariff to stimulate the development of multi-disciplinary and community services, working within the current structure. At present the tariff is not concordant with the policy direction.

Improving the system for budgetary allocation to mental health

As stated the current system of financial management is not to delegate budgets and to allocate resources based on a notional tariff based allocation. The tariff only covers hospital/institutional based medical services. This model is wholly inappropriate for the achievement of the national mental health policy or indeed for the efficient and rational use of resources as it locks services into hospital based models based around psychiatrists – this is potentially both expensive and inefficient and de-incentivises community development.

In the long run mental health would benefit from a proper system of delegated budgetary control as used in most modern businesses where mental health is a separate cost centre and can deploy resources within agreed parameters. There would still be a set of rules and possibly a contract set by senior management. However, such a reform would not be mental health specific and would be reliant on reform of the management systems in general hospitals as a whole. It could be piloted or run in shadow form before implementation. This is a fairly large undertaking but does not involve any restructuring. It would be well within the capability of any competent management consultancy or university management school to support such a change based on best international practice.

A short term recommendation however is to deal with the most perverse aspects of the current system by adjusting the current tariff. It is recommended that the current tariff which is used as the basis of resource allocation is adjusted to allow payment for community interventions and payment for interventions by non-psychiatric professional staff (social workers, psychologists and occupational therapists). This may necessitate small adjustments to the tariff as a whole. Relatively simple changes to the tariff could make a significant step in aligning the financial management system with policy.

It is not recommended that a sudden change is made to a DRG based payment system as already used in physical health care in Portugal and in physical and mental health care in many other countries, or to a modified system such as the Payment By Result (PBR) system used in England and being developed for mental health care which is an activity based system based on care clusters/care pathways. However, such as system may be a long term goal. The changes can be budget neutral overall, but would involve a shift towards the community. In the longer run consideration should also be given to length of stay issues.

Essentially however, the worst perverse disincentives could be removed by allowing reimbursement and setting a tariff for the following 5 activities:

- Home visit by a psychiatrist
- Community consultation by a psychiatrist
- Home visit by another qualified mental health practitioner
- Community consultation by another qualified mental health practitioner
- Group activity in the community supervised by another qualified mental health practitioner.

The team does not have the expertise to set this tariff but because both fixed and variable costs but these costs are not hugely difficult to estimate based on an average salary component (higher for psychiatrist) and an average on cost component (which will be the same for professional group but different for community and home visit settings) but they need to be done within Portugal by local financial experts or health economists. Counter-intuitively on-costs are often higher for home visits due to transport and travelling time related costs i.e. home visits may be inefficient if clinically and socially valuable.

Challenges and Recommendations

This report has provided a brief overview of the Portuguese mental health system, and throughout some problems have been identified. By European Union standards, Portugal has a small supply of mental health services, both of hospital beds and community services, unable to meet the potentially very high demand. This requires that services work in an optimally focused and efficient ways. Strengths are the strong Implementation Team and a highly motivated and competent mental health workforce, offering a foundation for further reform. Some improvements, within the limitations of present economic conditions are possible.

By the nature of assessments, it is tempting to offer a long list of challenges and recommendations. We have resisted this, because we prefer to select a few essential areas were change is feasible. The main challenges to be addressed are below, followed by a brief list of recommendations. We believe that many of the crucial changes could follow their enactment.

Challenges

1. Provision of essential services such as crisis services and residential places are inadequate, causing the blocking of the system as a whole.

2. The elements of the mental health system, incorporating primary care, community teams, hospitals and residential rehabilitation services are not clear about their priorities and lack coordination.

3. Unless primary care services can treat the large minority of people with anxiety and depression, specialist services will be paralysed due to the demand, unable to focus on people with severe and ongoing needs.

4. There are no incentives to increase both the medical and non-medical part of the mental health service active in the community, resulting in inefficiencies.

5. Mental health managers lack authority to implement changes by delegating mental health budgets.

6. The financing system has created unintentional disincentives to establish community based services, rewarding hospital admissions and medical interventions.

Recommendations

1. Increase capacity and competence to treat and support people with severe mental health problems in the community by establishing clear objectives for community teams.

2. Reduce (re)admissions by providing 24 hours a day access to emergency services.

3. Train primary care staff to identify, diagnose and treat people with anxiety and depression.

4. Increase the number of residential homes for persons with long term mental health problems in partnership between health and social sectors, allocating lead responsibilities to specific agencies in line with Decree8/2010.

5. Change tariffs to create incentives towards community interventions by medical and non-medical staff in order to prevent admissions and relapses and develop a whole system of care.

6. Continue the pilot funding that has encouraged service innovation, and safeguard sustainability.

7. At a Regional level, authority and responsibility should be placed for the monitoring of effective implementation of services and partnership across the system, based on quality standards.

Reference on tariffs

Mason,A. and Goddard,M. (2009) Payment by results in mental health: a review of the international literature and an economic assessment of the approach in the English NHS. Centre for Health Economics, University of York, England.

Programme WHO mission

16 February (Wednesday)

9.00-13.00 Almada general hospital + Oeiras community services
13:00 Lunch
14:30 – 17:00 Presentations and discussion

- Matt Muijen: Introduction
- JM Caldas de Almeida: General overview of the national plan implementation
- Álvaro Carvalho: Psychosocial rehabilitation program
- Miguel Xavier: Mental health legislation
- Pedro Mateus: Human resources
- António Leuschner: Services activities
- Isabel Fazenda: Social programs

17 February (Thursday)

9:00 – 13:00 Amadora general hospital + Amadora community services
13:00 -14:30 Lunch
14:30 – 17:00 Júlio de Matos Psychiatric Hospital
Miguel Bombarda Psychiatric Hospital

18 February (Friday)

9:00 – 12:30 Final discussion and decisions about next steps
12:30 Closure