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Community-based mental health care, Latvia

Provision of community-based mental health care, Latvia

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Abstract

Problem In Latvia, the move towards community-based mental health-care services has been slow.

Approach The hospital managers of the only psychiatric hospital in Riga decided to establish two community-based clinics that were financially and administratively integrated with the hospital. The clinics were established using a step-wise approach by redistributing resources, including psychiatrists, nurses and beds, from the hospital to the new clinics. In 2005, the Veldre clinic started outpatient consultations and day care admissions. In 2009, Pardaugava clinic opened as an outpatient clinic. In 2012, an open-door inpatient ward with 30 beds was transferred from the psychiatric hospital to Veldre. In 2013, Pardaugava clinic opened a day care clinic and an open-door inpatient ward, transferring 26 beds from the psychiatric hospital.

Local setting Latvians have poorer mental health than the average population in Europe. Mental care has traditionally focused on inpatient care.

Relevant changes The clinics are now providing most of the outpatient services and the number of inpatients treated at the hospital has declined from 5696 patients in 2004 to 4957 patients in 2018. Patients are treated in a more open and patient-centred environment.

Lessons learnt The administrative and financial integration of the new community-based clinics within the existing structures of the hospital is successful approach. Transferring resources to the clinics seems to have improved the quality of care without requiring additional funding apart from the initial investment costs. Involving the staff members during the planning phase reduced resistance to the project.
Introduction
The World Health Organization (WHO) promotes the development of community-based mental health-care services as part of a balanced care model.\textsuperscript{1,2} Nevertheless, policy-makers in many central and eastern European countries have struggled to develop adequate community mental health services, despite having national policies for such care provision in place.\textsuperscript{1,3}

Here we present the approach for establishing two community-based mental health clinics in Latvia.

Local setting
Latvia is a Baltic country with about 2 million inhabitants. Latvians’ mental health are on average poorer than that of other Europeans. For example, the number of deaths per 100,000 population caused by suicide or intentional self-harm was 16.2 in 2015, compared with 9.8 in the WHO European Region.\textsuperscript{4} Mental care has traditionally focused on inpatient care, and the move towards community-based mental health services has often taken place in response to pressures from international and human rights organizations.\textsuperscript{5} For example, WHO and the health ministry found in 2005 an insufficient development of provision networks outside of psychiatric hospitals.\textsuperscript{6} Although the number of psychiatric hospital beds has decreased from 186 beds per 100,000 population in 2000, to 126 beds per 100,000 population in 2014, the number is higher than the European average of 68 beds per 100,000 population.\textsuperscript{4} In the capital Riga, with about 641,000 inhabitants, one psychiatric hospital, the Riga Psychiatry and Narcology Centre, provided mental care.\textsuperscript{4}

Approach
To tailor service provision to patient needs and to enable greater continuity of care across outpatient and inpatient settings, the psychiatric hospital directors and chairman of the board decided in 2002 to establish a community-based clinic in Riga. Based on hospital statistics, the clinic should provide care for 4000 to 5000 patients living nearby the clinic, and therefore the location needed to be sufficiently populated. The location should also be accessible by public transport and be in a different administrative district than the hospital.

In 2005, the Veldre clinic started outpatient consultations and day care admissions after the hospital renovated an unused kindergarten building. To promote
community integration and reduction of stigma, the clinic was located next to a school. Based on the example of the Veldre clinic, a second clinic, Pardaugava, opened in 2009 as an outpatient clinic after renovating a rehabilitation facility for substance abusers and constructing a new building. In 2012, an open-door inpatient ward with 30 beds was transferred from the psychiatric hospital to Veldre. Finally, in 2013, Pardaugava opened a day care clinic and an open-door inpatient ward, transferring 26 beds from the locked ward at the psychiatric hospital.

To set up the clinics, the hospital managers decided to redistribute resources, including psychiatrists, nurses and beds, from the hospital to the clinics. All relevant staff members were involved in the planning of the new clinics.

Hospital staff members would keep their jobs but would have to work at the new locations, full- or part-time. Eventually, the clinics employed more staff for outpatient care since the patient load increased. Part-time staff usually work at the psychiatric hospital for the rest of the week. To ensure continuity, an outpatient requiring inpatient care is treated by the same psychiatrist.

As special training courses in community-based mental health care were unavailable, most community-based practice skills had to be acquired on the job. However, continuing education activities were available. For example, six times a year the Latvian Psychiatric Association Conferences provided free lectures lasting 3–4 hours, covering topics such as psychiatric rehabilitation, multidisciplinary team work and role of art therapies. Furthermore, three to five senior staff had the opportunity to visit similar facilities in Finland and the United Kingdom of Great Britain and Northern Ireland.

Patients receive psychiatric outpatient consultations without a referral, from 8:00 to 18:00, and patients with more complex needs are admitted for day care or inpatient care at the clinics. Admitted patients receive a tailored rehabilitation and treatment programme, including cognitive behavioural therapy, pharmacotherapy, art therapy, ergotherapy and physiotherapy. The development of the programme was informed by the literature and programmes in other countries. The day care programme focuses on nonpharmacological treatment, while inpatient care, which is reserved for patients with highly complex needs, focuses on, for example, identifying medications for treatment. Treatment is free of charge.
The psychiatric hospital is legally and financially responsible for the clinics and the directors of the clinics report to the chairman of the hospital board. The inpatient care is financed based on a global budget, and funding remains the same over time, while budgets for outpatient and day care are determined based on registered fee-for-service points. Inpatient service provision at the clinics did not require additional funding apart from the initial investments for construction and equipment of the new facilities, as the inpatient care budget was simply transferred from the hospital to the clinics. The total investment costs were 4,410,518 euros (€), of which € 3,748,940 was financial support from the European Union. Incentives exist on an individual level, both at the hospital and the clinics, to develop outpatient and day care. Psychiatrists (since 2005) and therapists (since 2019) receive an additional €7 fee-for-service based remuneration for outpatient visits from the health insurance system. This fee-for-service system financed new positions.

**Relevant changes**
In 2019, each clinic had seven psychiatrists employed on full-time contracts and four to seven psychiatrists working six hours per week. Between 2005 and 2013, 43 staff members were transferred from the hospital to the clinics. In addition, the clinics have hired 12 psychiatrists, eight nurses and 27 therapeutic specialists, either full time or part-time.

The clinics are now providing most of the outpatient services. In 2018, only 16,310 (29%) of the 55,997 visits took place in the hospital. Of the remaining outpatient visits, the Veldre clinic had 18,979 visits and Pardaugava clinic had 20,708 visits. The number of inpatients treated at the hospital has declined from 5,696 patients in 2004 to 4,957 patients in 2018. During the same period, the total number of inpatient days decreased from 318,541 days to 164,084 days. In 2018, 15% (886/5,843) of inpatients were treated at the clinics. The number of patients receiving day care treatment increased from 218 in 2004 to 457 in 2018.

The types of disorders treated by inpatient care differ between the clinics and the hospital. At the hospital such care is focused on psychotic disorders and organic mental disorders, while the clinics attract mostly patients with affective disorders, including depression, anxiety and bipolar disorders (Table 1).
Limited data is available on the quality of mental care in Latvia, and quality has not been systematically monitored.\textsuperscript{8} However, psychiatrists in the clinics receive positive feedback from patients on the continuity of care. Furthermore, the care provided at the clinics is much more in line with international recommendations for a balanced care approach.\textsuperscript{1} In addition, the clinics have piloted an adapted version of the Psychiatric Inpatient Patient Experience Questionnaire\textsuperscript{8} and the results showed that patients were generally satisfied with the care they received in the clinics.\textsuperscript{9}

**Lessons learnt**

The two clinics have been able to implement the community-based balanced care approach, treating patients in a more open and patient-centred environment. Patients and their psychiatrists appreciate this approach and evidence suggests that treating patients in a day-care setting reduces hospitalizations. However, demonstrating the effect of less hospitalization is difficult due to limited data availability.

Personal motivation of the hospital managers at the psychiatric hospital played an important role in the development of the clinics. Hospital managers wanted to be progressive and replace inpatient care with day care and outpatient care. Furthermore, health-care financing principles in Latvia stimulate the development of outpatient and day care activity.\textsuperscript{10}

The idea of establishing community-based clinics initially met resistance from psychiatrists and nurses. Staff members were reluctant to adopt new practices as these required a different mindset and new skills, for example, suicide risk management and dealing with patients not attending day-care treatment. In addition, many staff members were reluctant to relocation because of longer commuting time.

However, hospital managers addressed staff resistance by involving staff members in the planning process, by incorporating their suggestions in designing and equipping the new facilities, and by allowing them to shape the organization of work. Younger and open-minded staff were easier convinced of the benefits of community-based practice. Financial incentives for the provision of outpatient care also helped. In addition, some psychiatrists and nurses already lived close to the new clinics. In 2007, the director of Pardaugava clinic was elected President of the Latvian Psychiatric Association, which contributed to a neutral position of the association to the clinics.
The Latvian experience holds several lessons for other countries wishing to move psychiatric service provision away from hospitals and towards community-based care (Box 1). First, external pressure and recommendations of international organizations as well as external funding can contribute to developing community-based mental health services.\(^1\) Second, the administrative and financial integration of the new clinics within the existing structures of the hospital and the involvement of clinical staff in the planning process created a sense of security for the involved personnel and encouraged them to support the initiative. Third, the approach of transferring resources to a community-based clinic seemed to improve the quality of care without requiring additional funding apart from the initial investment costs. Finally, our experience shows that incentives of the financing system are important. The hard budget constraints for inpatient care combined with activity-based funding for outpatient and day care, coupled with fee-for-service-based remuneration for treating specialists created incentives that promoted the establishment of the clinics and the expansion of activity.

In 2019, the government adopted the Plan of Improving Access to Mental Health Care 2019–2020.\(^1\) The plan suggests the creation of seven new community-based mental health clinics across the country, modelled after the clinics in Riga. The old clinics will provide in-service education for staff of the new clinics, and the Latvian version of the quality questionnaire will be used in other mental health institutions. To strengthen the community outreach in Riga, plans exist to enable nurses to do home visits and family therapies.

**Competing interests:**
MT is director of the Veldre clinic. WQ has no competing interests.

**Reference**


5. Report to the Latvian Government on the visit to Latvia carried out by the European committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) from 12 to 22 April 2016. Strasbourg: Council of Europe; 2017. Available from https://rm.coe.int/pdf/168072ce4f [cited 2018 Jul 22]


Box 1. Summary of main lessons learnt

• External pressure by international organizations stimulated national efforts to develop community-based psychiatric care.

• Financial incentives to support the development of outpatient and day-care settings played an important role.

• Transferring resources from the hospital to the community-based clinics improved the quality of care without requiring additional funding.
Table 1. Distribution of mental health diagnosis at the hospital and community-based clinics, Latvia, 2019

<table>
<thead>
<tr>
<th>Diagnosis (ICD-10 code)a</th>
<th>Hospitalb No. of patients (%)</th>
<th>Veldre clinic</th>
<th>Pardaugava clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient n = 4901</td>
<td>Outpatient n = 5719</td>
<td>Inpatient n = 425</td>
</tr>
<tr>
<td><strong>Organic, including symptomatic, mental disorders (F0)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Outpatient</td>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td>Organic, including symptomatic, mental disorders (F0)</td>
<td>1370 (28.0)</td>
<td>1736 (30.4)</td>
<td>60 (14.1)</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders (F2)</td>
<td>2345 (47.8)</td>
<td>2258 (39.5)</td>
<td>140 (32.9)</td>
</tr>
<tr>
<td>Mood [affective] disorders (F3)</td>
<td>634 (12.9)</td>
<td>715 (12.5)</td>
<td>185 (43.5)</td>
</tr>
<tr>
<td>Neurotic, stress-related and somatoform disorders (F4)</td>
<td>346 (7.1)</td>
<td>686 (12.0)</td>
<td>38 (8.9)</td>
</tr>
<tr>
<td>Behavioural syndromes associated with physiological disturbances and physical factors (F5)</td>
<td>NA</td>
<td>38 (0.7)</td>
<td>NA</td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour (F6)</td>
<td>51 (1.0)</td>
<td>60 (1.0)</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Mental retardation (F7)</td>
<td>134 (2.7)</td>
<td>226 (4.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F8)c</td>
<td>21 (0.4)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

NA: not applicable.

a The categories are based on the main diagnostic groups of *International Statistical Classification of Diseases and Related Health Problems*, 10th edition.7

b The Riga Psychiatry and Narcology centre is the only psychiatric hospital in Riga.

c Mostly forensic expertise’s opinion for adolescences.

Note: Inconsistencies may arise due to rounding.

Source: We obtained the data from the Riga Psychiatry and Narcology centre.