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Letter from . . .

Spain

The new mental health care system in Navarra, Spain

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Your two correspondents are psychiatrists in their mid-30s working at two publicly-funded mental health centres in Navarra. We share the responsibility for co-ordinating the eight mental health centres, two day hospitals and two psychiatric units in general hospitals in the province. Each of us takes care of half these resources, grouped in a 'mental health area'.

Navarra is an autonomous province in northern Spain, by the Pyrenees, with a population of about 500,000. Half the population is concentrated around the capital, Pamplona.

We are currently in the midst of the so-called psychiatric reform process, which has been taking place in this country since 1986. Several authors (Marquinez, 1988; Inchauspe, 1989; Varo, 1989 among them), have written about this reform, which basically has to do with:

(a) the shift towards community care
(b) making mental health services available to the community
(c) providing mental health care through the primary care system
(d) creating psychiatric units in general hospitals, rather than using psychiatric hospitals for brief stays
(e) the creation of alternative resources to in-patient care for chronic patients
(f) considering prevention in mental health a priority
(g) working with social and welfare services.

In our particular case, after the approval of the mental health plan by the local parliament in 1986, steps were taken in order to establish the conditions needed for psychiatric reform to succeed.

Previously, mental health services were poorly co-ordinated (drug and alcohol dependency services, private institutions for mental health, a nationwide child psychiatric care system, etc.). Psychiatric hospitals housed around 1,000 patients. A political decision was taken to create a system which could provide the necessary means to fulfil goals of the reform. This was done by developing the network of eight mental health centres (MHCs), distributed throughout the province and covering an approximate population of 65,000. Each MHC has its own team, comprising at least one psychiatrist, one psychologist, one social worker, one nurse, and a secretary.

Where possible, the MHCs are in the same building as primary care facilities.

These eight MHCs work together with two day hospitals (of about 20 patients with a mean stay of 25 days) and two psychiatric units, each with 27 beds, two of them dedicated to a ten-day drug detoxification programme.

Mental health civil servants and professionals (both central and provincial) were offered the chance to work in the new mental health services. Most accepted, and different teams and services were 're-cycled' to form two mental health teams; four teams were completely new, and two were contracted from private practice. Similar procedures were followed to staff both the day hospitals and the general hospital units.

Our mental health network system was intended to support the primary care system. This means that patients reaching the MHC should have previously contacted their GPs who referred them for specific mental health care. This series of steps has not always been followed, however. This arose for several reasons:

(a) previous customs and practices: primary care physicians were used to dealing with mental health problems on their own (with counselling, or prescription of psychotropic drugs, etc.) or they referred patients for neuropsychiatric out-patient consultation, for psychiatric in-patient care, or to specialist services, such as for drug and alcohol dependency services and child psychiatry

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TABLE I
Amount of activity in mental health centres in Navarra 1988–89 variation (%)

	1988	*1989*	*89/88 (%)*
Number of people contacting for the first time	4,829	5,250	8.7
Total number of people in touch with the MHCs	8,304	10,375	24.9
Total number of consultations	57,703	65,011	12.6
Consultations/patient/year	6.9	6.3	−8.7
First/following consultations rate	11	11.4	3.6
Incidence	9.4	10.2	8.5
Prevalence	16.2	20.2	24.7
Frequency	112.6	126.8	12.6

TABLE II
New patients access to mental health centres, 1989

Access (totals)	*IA*	*IB*	*IC*	*IIA*	*IIB*	*III*	*IV*	*V*	*Total*
Direct access	30	95	115	72	247	96	27	42	724
Access through primary care	373	589	459	378	453	250	172	424	3,098
Others (Emergency room, hospitals, other doctors', welfare services, school system, etc)	50	150	286	303	277	109	81	172	1,428
Access (%)	*IA*	*IB*	*IC*	*IIA*	*IIB*	*III*	*IV*	*V*	*Total*
Direct access	6.6	11.4	13.4	9.6	25.3	21.1	9.6	6.6	13.8
Through primary care	82.3	70.6	53.4	50.2	46.4	54.9	61.4	66.5	59.0
Others	11.0	18.0	33.3	40.2	28.4	24.0	28.9	27.0	27.2
Total	100	100	100	100	100	100	100	100	100

These tables come from the Annual Report, Dirección de Salud Mental, Gobierno de Navarra.

(b) the delayed development of primary care teams, which in 1987, covered only around 40% of the population (the new mental health care system was fully developed by mid-1987)

(c) the existing relationships of patients and professionals, previously working in other psychiatric services.

In spite of these difficulties, we have observed an annual, gradual increase of referrals through primary care.

Differences between centres are striking and have to do with each MHC's history, professional profile, and work orientation (community v. 'desk' practice). Tables I and II give an idea of the work of these centres. Trying to provide a basic, homogeneous level of good community mental health care is one of our main worries and challenges. Most health professionals in Spain have been trained in solely clinically orientated setting, paying scarce, if any, attention to community factors influencing general health and well-being. Team-work is not taught, and its practice is scarce, and not at all facilitated by the long-established professional differences in social status, wages, opportunities, etc.

Our challenge, again, as clinician co-ordinators is finding ways to motivate people in working towards this, we think better, way of doing things. We feel that communication between centres, participation in decision making, and sharing of responsibilities contribute to our purpose.

What of the near future? We hope to maintain the secondary level of specialist mental health care,

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helping the primary care system rather than working in parallel or instead of it. Clear and effective co-ordination is required with the social and welfare services. The education and preparation of new professionals in this style of working is essential. Alternative resources for chronic and new chronic patients are needed.

To these ends, the exchange and contrast of experience is of great value, and we hope this letter is a step towards this goal.

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People and places

Psychiatry at Keele: germination of a new department

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The 40th anniversary celebrations at Keele are proving to be a lively acknowledgement that the University is now firmly back on its feet and has a renewed confidence in its baptismal vows. There has indeed been a recovery of Keele's *raison d'être* to provide multi-faculty education (all students study an arts and science subject), to pioneer a Foundation Year to allow more informed choice of Honours courses, and to accommodate undergraduates as well as many staff on its leafy 18th century estate. The Vice Chancellor has succeeded in putting Keele back in the black, and on the map, and now plans to increase the number of students to 6,000 in the next decade.

But where, the reader may ask, does academic psychiatry and postgraduate medical education fit into this liberal-arts campus University life style? The answer goes back to the 1960s when a strong bid for an undergraduate medical school was made but which, after several years of negotiation with the UGC, was rejected – no such new institution was to be created. There was surprise, therefore, and no doubt some hurt feelings, when a new medical school *was* established at Leicester which left the West Midlands with a population similar in size to Scotland having only one medical school 50 miles South in Birmingham. Nevertheless out of these ashes arose the realisation that a Postgraduate Medical School might be financed by the Health Service which would meet the need to improve local medical care and yet be consistent with Keele's particular educational ethos.

This development, therefore has come about through the farsightedness of the physicians, and of the District and Regional Health Authorities in the mid 1970s, and the need for a University Department of Postgraduate Medicine to assist in troubled financial times. This initiative was maintained by the creative attitudes of the consultants in the District General Hospital (1,000 beds) and from the consistent support of the population in North Staffordshire, who realised that money invested in medical education would improve the quality of their health care. Indeed the North Staffordshire Medical Institute, one of the largest in the country with a substantial journal library and two lecture theatres, was partially built with money from the pay packets of the potters.

How is it that psychiatry in January 1986 became among the first medical academic developments at Keele and is now one of the largest departments? Dr J. A. Hutchinson, Consultant and Clinical Tutor in North Staffordshire for 30 years and his wife Doreen, a consultant child psychiatrist, were among

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