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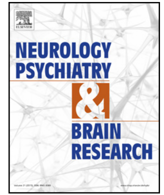

Psychiatric Care Planning in Lower Austria—A long-term Project

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ABSTRACT

The history of mental health planning in Lower Austria is inextricably linked with the history of the Gugging psychiatric hospital which closed in 2007. We will, therefore, trace Gugging's history from its foundation up to the period after its closure. This will help to identify the different phases in mental health planning in Lower Austria.

Covering an area of 19,186 km^2, Lower Austria is the largest of Austria's nine provinces and has the second largest population after Vienna (more than 1.6 mio inhabitants). It is divided into 25 administrative districts, and its typical rural landscape poses the corresponding challenges for the optimum planning of psychiatric care. In this paper, we will trace a path from its historical routes, through modern mental health planning in Lower Austria, to the present day.

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1. Architecture phase—from asylum to hospital

The story begins in 1885, when an offshoot of the Vienna mental asylum was opened in Gugging – 15 km from Vienna – to accommodate 105 inmates and 16 warders. This was done in response to the dramatic increase in cases of illness at the time, which were attributed to different causes. Not least was the growing intolerance in industrial society, which was no longer prepared to the same extent to keep and care for mentally ill and socially maladjusted people within the family. At the time, the Lower Austria Provincial Committee, as it was called, set out in its statements of accounts the principles for assessing the requirement for care, on the basis of which the Provincial Parliament decided on the number and structure of care places and their financing. This can, therefore, be regarded as the first documented psychiatric care planning in Lower Austria. The treatment concept was based on the non-restraint model, which was reflected in the architectural design. Today, too, a connection can still be seen between the architecture and care plan, in the case on the one hand of the specialist psychiatric hospitals – generally established historically – and on the other of the newer psychiatric unis in general hospitals. A more detailed comparison of the two care concepts is long overdue. But there are also no known evaluations from that time. In fact, however, the new pavilion structure generally prevailed and Gugging served as a model for further establishments in Austria. This type of architecture was the expression of a widespread treatment concept with fewer restrictions and more opportunities for the patients to work, as well as the cure advocated at the time of spending more time in the fresh air.

2. Eugenics phase—from hospital to murder clinic

During the First World War, Gugging served as a military hospital, and severe supply shortages led even here to patients dying of hunger. In the Second World War, under a diabolical director installed by the Nazi regime, Gugging became one of the most evil selection and murder clinics for both adult patients and minors. The steps taken to empty the wards led to a systematic, planned annihilation of the patients.

3. Frantic deinstitutionalisation phase

The number of patients increased again in the post-war years, with the proportion needing long-term care growing constantly. In the 1960s, this led to serious overcrowding; the available accommodation was no longer adequate for the number of patients hospitalized. In reaction, a "frantic dehospitalisation" of patients into care homes occurred, the consequences of which are still evident now.

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4. Psychiatric reform phase

At the same time, the first off-shoots of the newly introduced psychiatric reforms made themselves felt, triggered on the one hand by the 1975 German Federal Psychiatry Inquiry (Salize, Rössler, & Becker, 2007) and on the other by the psychiatric policy developments occurring at the same time to close psychiatric institutions in Italy (Amaddeo, Barbui, & Tansella, 2012). When these reforms began, a psychiatrist, Alois Marksteiner (Marksteiner & Rainer Gugging, 1985) took over as director and with his reforming spirit became a driving force behind them. His charisma enabled him to convince the Province's policy makers of the necessary reform measure,s and Heinz Katschnig was a congenial scientific colleague to his cause. This collaboration laid the foundation stone for mental health planning in Lower Austria. At about the same time mental health planning activities were initiated across the country (Katschnig & Denk, 2004).

5. Modern mental health planning phase

Publication of the first Lower Austrian Mental Health Plan in 1995 (Katschnig, 1995) laid the foundations for the overall direction of psychiatric care in Lower Austria. In contrast to the care provided centrally by two specialist psychiatric hospitals with shared treatment responsibilities at that time (Gugging for the Eastern and Mauer for the Western part of Lower Austria), a decentralised, regional care principle was advocated. Under this system, on the one hand the central care role of the existing large institutions was to be reduced to regional responsibility for the surrounding area. On the other hand, new regional units to be created in general hospitals were to take over responsibility for care in the regions where it had previously been provided centrally.

6. The Lower Austrian Mental Health Plan 1995, see Textbox 1 (Katschnig, 1995):

The Lower Austrian Mental Health Plan1995 set the direction for the reform measures in the form of 12 guidelines. The first of these was a shift from the traditional focus on institutions to a focus on need. Together with the objective of proximity to the community and the regionalisation of care, this mental health plan took on the key challenges of the time.

From a present-day perspective, it is striking that the planning of care structures ("little boxes") predominated, i.e. little consideration was given to processes, developments and correlations. Integrated models were not yet current, as these only developed in the wake of the new financing models. Albeit with a considerable decline of importance, the continued existence of the two psychiatric hospitals Gugging and Mauer was not questioned.

7. First implementation steps

Between 1998 and 2000, three psychiatric units were opened at general hospitals, each of them taking over care responsibility for the population of a defined catchment area. Right from the start, these wards have been open, and the rates of involuntary admissions could be significantly reduced compared to those of the psychiatric hospitals.

8. The Lower Austrian Mental Health Plan 2003 (Katschnig, Denk, & Weibold, 2003)

Originally planned as an evaluation of the Lower Austrian Mental Health Plan, this re-assessment of the 1995 proposals and of the changes in psychiatric care that had occurred in the meantime resulted in a multiplicity of requirements for adaptations. Since the 1995 Mental Health Plan, the following significant changes in psychiatric care and related matters required a complete re-assessment:

- *Introduction of service-based hospital financing (DRG System).*
- *Requirement plans for health services (incl. hospital bed capacities) and various amendments to laws at national and provincial level.*
- *Care plans for individuals with addiction and with intellectual disabilities.*
- *Increased development of groups representing the interests of mental health service users and their relatives.*
- *Dispersal of patients with intellectual disabilities from psychiatric clinics (through discharge and transfer to other institutions or living arrangements).*
- *Opening of psychiatric units in three general hospitals in Lower Austria.*
- *Political decision to close the Gugging hospital by 2007.*

The resulting focus on these points and the results of an own investigation with a mapping of all relevant institutions and services in Lower Austria (structure, personnel and client data) led, inter alia, to the following innovations:

Textbox 1. .

TWELVE GUIDELINES

1. Focus on need instead of institutions
2. Proximity to the community
3. Regional basis and obligation to provide care for the region
4. Continuity of care
5. Shift in emphasis from inpatient, to partial inpatient, outpatient and complementary care
6. Integration of psychiatric care into the general health care system
7. Subsidiarity principle—coordination between the private sector and state support for treatment and care needs not covered by the private sector
8. Participation of all stake holders involved – professionals, relatives and patients – in the planning process
9. Resource priorities—staff, transport/communications, building
10. New financing model – regional psychiatric care budget
11. Quality assurance measures
12. Institutionalisation of planning – psychiatric officer/psychiatric care planning agency and psychosocial working community

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