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Community Mental Health

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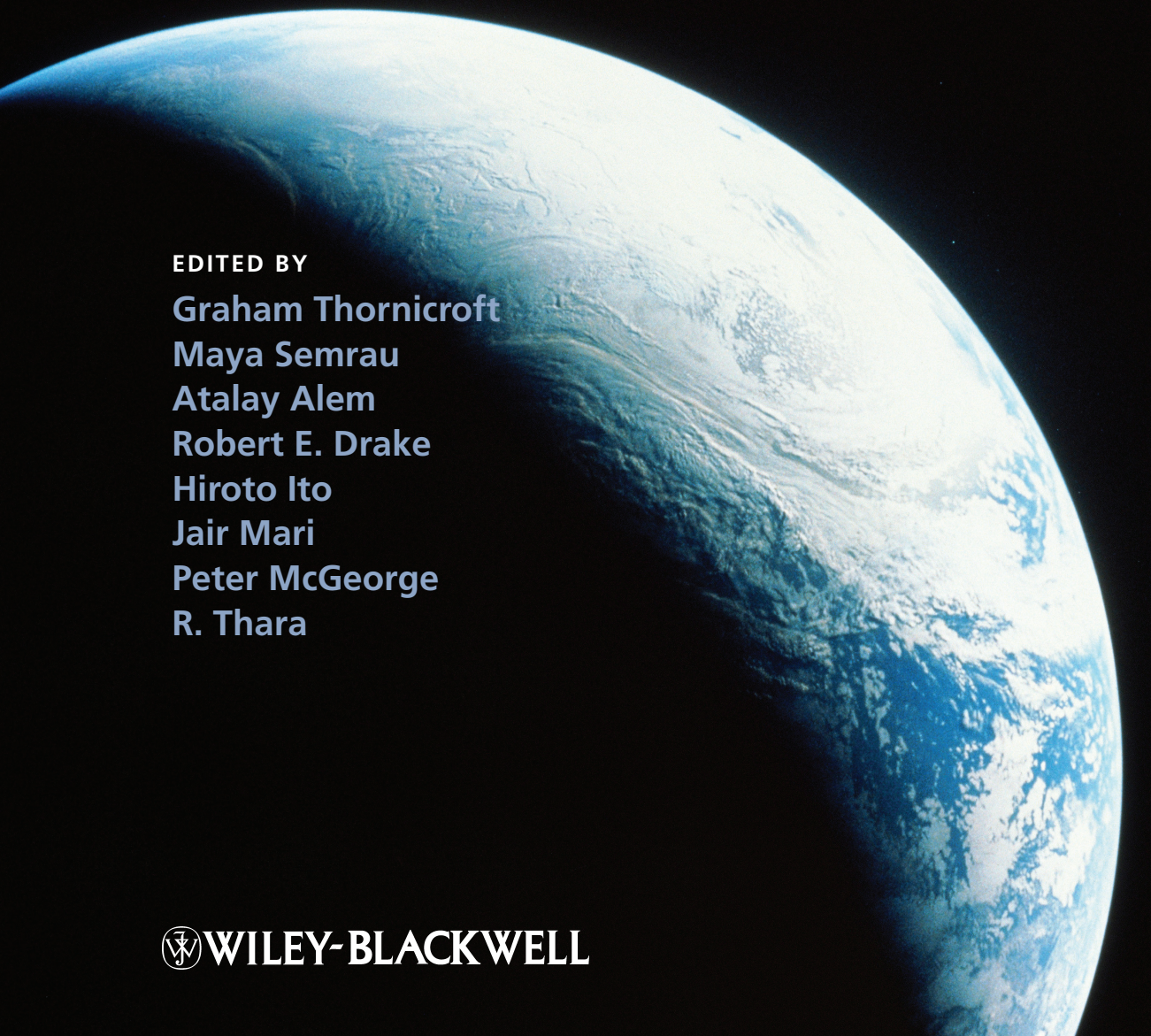

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Foreword

The development of community mental health care is currently ongoing, or at least planned, in many countries worldwide. The World Psychiatric Association (WPA) supports this process, aimed at allowing persons with mental disorders to have services available as close as possible to their locality, to be treated in the least restrictive environment, and to maintain their links within the community. We expect the implementation of community mental health care to improve patients' clinical outcomes, subjective quality of life, and satisfaction with care.

Experience has shown that the steps to be followed, the obstacles to be removed, and the mistakes to be avoided in the implementation of community mental health care are remarkably similar worldwide. The WPA decided therefore to establish a task force with the mandate to produce guidance on those issues, intended for psychiatrists, other mental health professionals, and policy makers of all countries of the world. This task force, led by Graham Thornicroft and including experts from all continents, completed the guidance in early 2010. The text was published in the June 2010 issue of *World Psychiatry*, the official journal of the WPA [1], and was posted on the Association's Web site. The guidance has since been translated into several languages, and all the translations have been uploaded on to the same Web site. The document is being extremely well received by the WPA Member Societies (i.e. national psychiatric societies) and by the psychiatric community, and there are already indications that it is being perused by administrators and policy makers from several countries.

Although the steps, obstacles, and mistakes to avoid in the implementation of community mental health care are very similar worldwide, there are regional and national differences, depending on a variety of factors, including the availability of human and financial resources, the level of priority assigned to mental health care by local administrators, and the attitudes of the general population towards mental disorders. It was therefore felt necessary to complement the WPA guidance with documents that delineate the mental health scenario in the various regions of the world and to provide specific recommendations for the development of community mental health services in those regions. A series of papers focusing on the

implementation of community mental health care in Africa, Australasia and South Pacific, Europe, North America, Latin America and Caribbean, South Asia, and East and South-East Asia was therefore commissioned and is being published in *World Psychiatry*.

The present volume represents an extension of that series, providing an overview of mental health policies, plans, and programs, a summary of relevant research efforts, a critical appraisal of community mental health service components, and a discussion of the key challenges, obstacles, and lessons learned in the various regions of the world, followed by some recommendations for the future, based on evidence and experience.

We believe that this book represents a very useful resource for all mental health professionals and for all policy makers involved in the mental health field. They will find here not only a picture of the current situation (which can be found, although in bits and pieces, elsewhere) and an outline of the principles of community mental health care (also available in many international documents), but also (and this is unique) a distillate of the experience of several professionals who have been active in community mental health care for decades and are willing to share what they have learned with their colleagues worldwide. The book is recommended to residents in psychiatry and trainees in other mental health professions, who will find it a treasure trove of information and ideas not generally available in textbooks or manuals used in their training.

Professor Mario Maj
President of the World Psychiatric Association

Reference

[1] Thornicroft G, Alem A, Dos Santos RA, et al. WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. World Psychiatry 2010;9:67–77.

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The work which led to this book was commissioned by Professor Mario Maj, President of the World Psychiatric Association, and we are most grateful to Professor Maj for his strong support in establishing the Task Force which undertook it. The authors are pleased to acknowledge the rich contributions of all members of the regional teams that contributed to the various chapters, as given in the List of Contributors.

SECTION 1
Introduction

CHAPTER 1
Global mental health: the context

Introduction

Mental health problems are common, with over 25% of people worldwide developing one or more mental disorders at some point in their life [1]. They make an important contribution to the global burden of disease, as measured by disability-adjusted life years (DALYs). In 2004, for example, neuropsychiatric disorders accounted for 13.1% of all DALYs worldwide, with unipolar depressive disorder alone contributing 4.3% towards total DALYs. In addition, 2.1% of total deaths worldwide were directly attributed to neuropsychiatric disorders. Suicide contributed a further 1.4% towards total deaths, with 86% of all suicides being committed in low- and middle-income countries (LAMICs) each year [2]. A systematic review of psychological autopsy studies of suicide reported a median prevalence of mental disorder in suicide completers of 91% [3]. Life expectancy is up to 20 years lower in people with mental health problems than in those without, due to their higher levels of physical illnesses and far poorer health care [4]. Mental health problems therefore place a substantial burden on individuals and their families worldwide, in terms of both diminished quality of life and reduced life expectancy. The provision of any (let alone high-quality) mental health care is vital in reducing this burden [5].

It is in this context that the aim of this book is to present guidance on the steps, obstacles and mistakes to be avoided in the implementation of community mental health care, and to make realistic and achievable recommendations for the development and implementation of community-oriented mental health care worldwide over the next 10 years. We intend that this guidance will be of practical use to the whole range of mental health and public health practitioners at all levels, including policy makers, commissioners, funders, nongovernmental organizations (NGOs), service users and carers. Although a global approach has been taken, the focus

Community Mental Health: putting policy into practice globally, First Edition. Graham Thornicroft, Maya Semrau, Atalay Alem, Robert E. Drake, Hiroto Ito, Jair Mari, Peter McGeorge, and R. Thara.

is mainly upon LAMICs, as this is where challenges are most severe and most pronounced.

What is community-oriented mental health care?

How can we understand and define community-oriented mental health care? Historically speaking, in the more economically developed countries, mental health service provision has been divided into three periods [6]:

1. The rise of the asylum (from around 1880 to 1955), which was defined by the construction of large asylums that were far removed from the populations they served.
2. The decline of the asylum or "deinstitutionalization" (after around 1955), characterized by a rise in community-based mental health services that were closer to the populations they served.
3. The reform of mental health services according to an evidence-based approach, balancing and integrating elements of both community and hospital services [6–8].

One particular approach that can be useful is the "Balanced Care Model". This is the view that there is no strong evidence that a comprehensive mental health service can be provided with inpatient services alone, nor with community services alone. Rather there needs to be a careful balance of community-based and hospital-based care. The precise mixture of these elements needed will be quite specific to any particular time and place. Nevertheless, the Balanced Care Model is based upon a set of fundamental principles, namely that services should:

- be close to home
- provide interventions for disabilities *and* for symptoms
- be specific to the individual needs
- reflect the priorities of service users
- include both mobile and static services.

In practice these principles will usually mean that most mental health and related services will need to be provided in settings close to the populations served, with hospital stays being reduced as far as possible (in number and duration), and that over time a progressively greater proportion of the mental health budget is spent upon community rather than hospital services [9].

The resources available in LAMICs are so far below those in high-income countries that the Balanced Care Model is organized in a tiered way to indicate service developments that are feasible and realistic at difference levels of resource. For example, the number of psychiatrists per 100 000 population is 5.5–20.0 in Europe and 0.05 in Africa, while there are 87 beds for the same population in Europe compared with 0.34 in Africa,

and the proportion of the total health budget dedicated to mental health is 5–12% in Europe and less than 1% on average in Africa. Therefore, to take each resource level in turn:

1. In low-resource settings, the focus is on establishing and improving the capacity of primary health care facilities to deliver mental health care, with limited specialist back-up. Most mental health assessment and treatment occurs, if at all, in primary health care settings or in relation to traditional/religious healers. For example, in Ethiopia, most care is provided within the family or close community of neighbors and relatives: only 33% of people with persistent major depressive disorder reach either primary health care or traditional healers [10, 11].
2. In medium-resource settings, in addition to primary care mental health services, an extra layer of general adult mental health services can be developed. This consists of all of the following five categories: outpatient/ambulatory clinics; community mental health teams; acute inpatient services; community-based residential care; and work, occupation and rehabilitation services (see Appendix A for further descriptions of these services).
3. In high-resource countries, in addition to the services indicated for points 1 and 2, as more resources become available, more specialized services can be provided, in the same five categories. These may include, for instance, specialized outpatient and ambulatory clinics, assertive community treatment teams, intensive case management, early intervention teams, crisis resolution teams, crisis housing, community residential care, acute day hospitals, day hospitals, nonmedical day centers, and recovery/employment/rehabilitation services. It is this Balanced Care Model that is used here as the overall framework in considering community-oriented care. This model is described in more detail in Chapter 10.

In low-resource settings, community-oriented care will be characterized by:

- A focus on population and public health needs.
- Case finding and detection in the community.
- Locally accessible services (i.e. accessible in less than half a day).
- Community participation and decision-making in the planning and provision of mental health care systems.
- Self-help and service-user empowerment for individuals and families.
- Mutual assistance and/or peer support of service users.
- Initial treatment by primary care and/or community staff.
- Stepped care options for referral to specialist staff and/or hospital beds if necessary.
- Back-up supervision and support from specialist mental health services.
- Interfaces with NGOs (for instance in relation to rehabilitation).

- Networks at each level, including between different services, the community, and traditional and/or religious healers.

Community-oriented care, therefore, draws on a wide range of practitioners, providers, care and support systems (both professional and nonprofessional), though particular components may play a greater or lesser role in different settings depending on the local context and the available resources, particularly trained staff.

Fundamental values and human rights

Underpinning the successful implementation of community-oriented mental health care is a set of principles that relate on the one hand to the value of community and on the other to the importance of self-determination and the rights of people with mental illness as persons and citizens [12, 13]. Community mental health services emphasize the importance of treating and enabling people to live in the community in a way that maintains their connection with their families, friends, work, and community. In this process it acknowledges and supports the person's goals and strengths to further his/her recovery in his/her own community [14].

A fundamental principle supporting these values is the notion of people having equitable access to services in their own locality in the "least restrictive environment". While recognizing the fact that some people are significantly impaired by their illness, a community mental health service seeks to foster the service user's self-determination and his/her participation in processes involving decisions related to his/her treatment. Given the importance of families in providing support and key relationships, their participation (with the permission of the service user) in the processes of assessment, treatment planning, and follow-up is also a key value in a community model of service delivery.

Various conventions identify and aim to protect the rights of service users as persons and citizens, including the recently ratified United Nations (UN) Convention on the Rights of Persons with Disability (UNCRPD) [15] and more specific charters such as the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Care, adopted in 1991 [16].

These and other international, regional, and national documents specify the right of the person to be treated without discrimination and on the same basis as other persons; the presumption of legal capacity unless incapacity can be clearly proven; and the need to involve persons with disabilities in policy and service development, and in decision-making which directly affects them [16]. This book has been written to explicitly align

with the requirements of the UNCRPD and associated treaties and conventions.

How information has been gathered for this book

This book has been produced by taking into account the key ethical principles, the relevant evidence, and the combined experience of the authors and their many collaborators. For the Africa region, for example, an expert survey was conducted to collect information on the experience of colleagues who have been active in the last decade in developing mental health services. In relation to the available scientific evidence, systematic literature searches were undertaken to identify peer-reviewed and grey literature concerning the structure, functioning, and effectiveness of community mental health services or obstacles to their implementation. These literature searches were organized for the World Health Organization's (WHO) regions, reflecting the locations of the book's authors. Yet there are limitations to this approach; in particular, the WHO Eastern Mediterranean region was not fully represented. Also, as this book focuses upon adult mental health services, it does not directly address the service needs of people with dementia or intellectual impairment, or of children with mental disorders.

Systematic literature searches

Systematic literature searches were conducted for the different WHO regions to identify peer-reviewed and grey literature. It was important to search for grey literature for two reasons. First, an underrepresentation in databases of indexed journals of publications from LAMICs has been identified [17, 18]; work conducted in such countries may therefore be found elsewhere. Second, reports produced by government bodies and charities concerning the development of community mental health services may contain valuable information concerning lessons learned, but are unlikely to be found in databases of peer-reviewed journals.

A search strategy was devised with the help of a specialist mental health librarian. This was carried out in each WHO region according to local expertise and resources. For each region, searches were limited to studies in humans, studies conducted in the relevant countries, and studies published in languages spoken by the relevant authors; for instance, for the chapter on the European region, studies were limited to those published in English, and for the African region studies in English and French were included.

Table 1.1 provides an overview of the search methods for each region. As an example of the regional searches, a detailed overview of the search methodology employed in the Africa region is provided in Box 1.1.

Table 1.1 Sources searched by regional authors to identify peer-reviewed and grey literature concerning the structure, functioning, and effectiveness, or obstacles to implementation, of community mental health services.

WHO region	Database searched	Other electronic searches	Supplementary searches	Other
Africa	MEDLINE, EMBASE, PsycINFO	Google	Reference lists of included articles Hand searches of the last five years of: *African Journal of Psychiatry*, *South African Journal of Psychiatry*, *International Psychiatry*	Questionnaire survey of regional experts. 21 responses (n) from: Cote D'Ivoire (1), Kenya (3), Liberia (1), Malawi (1), Niger (1), Nigeria (3), South Africa (3), Sudan (1), Tanzania (1), Uganda (3), Zimbabwe (2), NGO (1)
Australasia and South Pacific	MEDLINE	Google	Reference lists of included articles	
East and South East Asia	MEDLINE	Google	Reference lists of included articles	Email survey of regional experts in China, Indonesia, Japan, Singapore, South Korea, and Thailand
Europe	MEDLINE, EMBASE, PsycINFO	Google, OpenSIGLE, Web of Knowledge (ISI), WorldCat Dissertations and Theses (OCLC)	Reference lists of included articles	
Latin America	MEDLINE, Lilacs, EMBASE and SciELO	WHO, PAHO, Google, Mental Health Associations, World Psychiatry Association, Ministry of Health of LAC countries	Reference lists of included articles	
North America	MEDLINE, PsycINFO		Corrigan et al. 2008 [19]	
South Asia	MEDLINE	WHO, World Psychiatry	Reference lists of included articles	

Key texts, such as WHO reports [32–34], papers published by the current authors [6, 7, 22], and a special issue of the *Lancet* in 2007 concerning global mental health [26–31], were also sourced by all regional authors. (NGO, Nongovernmental organization; PAHO, Pan American Health Organization; LAC, Latin American and Caribbean.)

Box 1.1 Literature search strategy for the Africa region.

MEDLINE, EMBASE and PsycINFO databases were searched using the following search terms: (community mental health/or community mental health centers/or community mental health services/) OR (community care.mp. [mp = title, abstract, heading word, table of contents, key concepts]) OR (mental health care provision.mp. [mp = title, abstract, heading word, table of contents, key concepts]). The following key words were also used to search for relevant articles: (community mental health teams OR CHMT OR case management OR assertive community treatment OR assertive community outreach OR early intervention OR home treat* OR crisis hous* OR crisis resolution OR crisis support OR acute care OR acute day care OR inpatient unit* OR resident* OR balanced care OR primary care/(Subject heading) OR rehabilitation OR outpatient OR ambulatory) AND (mental OR psychiatr*) AND (africa or african).lo.(In MEDLINE and EMBASE, the suffix "cp" (country of publication) rather than "lo" (location) was used). The search was limited to English or French publications. Publications relating to services for children, the elderly, substance misuse, or people with intellectual disability were excluded. We also excluded mental health service interventions in a post-conflict context. Obtained abstracts were independently assessed for relevance by two contributors. We then attempted to obtain the full papers for all abstracts designated "relevant" or "possibly relevant" by either reviewer.

Google was searched on 02/11/2009 using an advanced search as follows:

Words: community mental health (in the text of the page) AND individual African countries. Limits: PDFs (hits in any language, but only selected English or French pages). Searched for papers relating to "development" or "evaluation" of overall mental health services (i.e. not specific interventions or groups). NOT children/adolescents. Newsletters and journalistic pieces excluded. If >300 hits, then searched within hits for "development".

In addition, references of obtained articles were checked for other relevant articles. The last five years of the following journals were manually checked for relevant articles: *African Journal of Psychiatry*, *South African Journal of Psychiatry* and *International Psychiatry*.

MEDLINE was searched for every region. Other databases searched were EMBASE, PsycINFO, LILACS, SciELO, Web of Knowledge (ISI), WorldCat Dissertations and Theses (OCLC), and OpenSigle. Searches, adapted for each database, were for MESH terms and text words relating to community mental health services and severe mental illness. Other electronic, nonindexed sources, such as the WHO, Pan American Health Organization (PAHO), WPA, other mental health associations, and country-specific Ministry of Health Web sites were also searched. Google was searched for PDFs published in European and African countries which contained the words "community mental health". The titles, abstracts, or Web pages of identified grey literature were scanned in order to identify publications relating to the development of community mental health services.

Electronic searches were supplemented by searches of the reference lists of all selected articles. Hand searches of issues from the past five years of