

CHAPTER 1

Introduction to community mental health care

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Community mental health care has evolved as a discipline for over 50 years now. In describing this evolution as well as current approaches, this book combines traditional concepts, such as community-based interventions and an epidemiological perspective, with newer concepts, such as recovery philosophy, evidence-based practices, and implementation fidelity, which have shaped the field over the past decade. Like community mental health care itself, the book is multidisciplinary and pluralistic. It addresses controversies and also emphasizes areas of convergence, where social values, medical science, and policy forces agree on specific directions.

Defining community mental health

Our definition of community mental health, shown in Box 1.1, highlights several fundamental issues. First, community mental health assumes a public health perspective (Levine and Petrilla, 1996). As summarized by Thornicroft and Tansella (2009), this encompasses: 1) a population view, 2) patients in a socioeconomic context, 3) generating information on primary prevention, 4) individual as well as population-based prevention, 5) a systemic view of service provision, 6) open access to services, 7) team-based services, 8) a long-term, longitudinal, life-course perspective, and 9) cost-effectiveness in population terms. This perspective also includes a commitment to social justice by addressing the needs of traditionally underserved populations, such as ethnic minorities, homeless persons, and immigrants, and to provision of services where those in need are located and in a fashion that is acceptable as well as accessible (Thornicroft et al., 2010).

Second, community mental health care focuses primarily on the people who experience mental illnesses. It emphasizes not just their deficits, needs, and disabilities (an illness perspective), but also their strengths, capacities, and aspirations (a recovery perspective). Services and supports thus aim to enhance a person's ability to develop a positive identity, to frame the illness experience, to self-manage the illness, and to pursue personally valued social roles (Slade, 2009).

Third, community mental health care includes the community in a broadly defined sense. As a corollary of the second point, it emphasizes not just the reduction or management of environmental adversity, but also the strengths of the families, social networks, communities, and organizations that surround people who experience mental illnesses (Rapp and Goscha, 2006; Warner, 2000). Mental illnesses are embedded in and partially determined by social and environmental contexts. Services must therefore comprise a wide network of interlocking components, including physical health care, housing, social services, religious organizations, peer supports, self-help organizations, and informal support systems. Because social and environmental forces impinge strongly on people who experience mental illnesses, community mental health must attend to these larger social forces in ways that are both ethical and pragmatic.

Fourth, community mental health melds medical science and recovery philosophy. A scientific approach to services prioritizes using the best available data on the effectiveness of interventions. At the same time, people who experience mental illnesses have the right to understand their illnesses (to the extent that professionals understand them), to consider the available options for interventions and whatever information is available on their effectiveness and side effects, and to have their preferences included in a process of shared decision-making (Drake et al., 2009a). In recent years, traditional definitions of recovery that focus on the complete remission of symptoms and illness-related deficits have been replaced by definitions that view recovery as a personally meaningful process that involves growth and adaptation in the community, irrespective of symptoms and impairments (Davidson et al., 2009; Slade, 2009). A commitment to recovery emphasizes helping people to overcome their illnesses and achieve their goals to the greatest extent possible and values their full participation in the service system and in their communities.

Community mental health care is shaped by a variety of values and forces that often conflict. Some values derive from the larger society—especially those expressed through a government's social policy on the one hand, and through medical science on

Box 1.1 Definition of community mental health care

Community mental health care comprises the principles and practices needed to promote mental health for a local population by: 1) addressing population-based needs in ways that are accessible and acceptable; 2) building on the goals and strengths of people who experience mental illnesses; 3) promoting a wide network of supports, services, and resources of adequate capacity; and 4) emphasizing services that are both evidence-based and recovery-oriented.

the other; while others derive from the smaller groups of participants directly engaged in mental health issues—those of service users, carers, and health professionals (Banton, 1985; Perkins and Repper, 1998). An analysis of community mental health thus requires an examination from multiple perspectives. It also requires the application of the methods of a variety of academic disciplines, including the behavioural and social sciences, history, politics, and, since questions of value are so central, moral philosophy and ethics.

The evolution of community mental health care

In the initial phases of deinstitutionalization, attempts to recreate the hospital service environment in the community had the unintended effect of perpetuating segregation, paternalism, passivity, dependency, low expectations, stagnation, stigma, and hopelessness (Nelson et al., 2001). At that time, community-based alternatives, such as nursing homes, group homes, day hospitals, day treatment programmes, and sheltered workshops, commonly replicated the stultifying environments of long-term hospitals. The typical ‘deinstitutionalized’ mental health client trudged from a supervised group home to a supervised group day programme and then perhaps to a supervised group outing. Segregation, dependence, and stigma were blatant aspects of such care. Mental health clients in these settings were often treated as though they were incompetent children who could not make decisions, manage their own illnesses, live on their own, integrate into their communities, work competitively, or pursue friendships and leisure activities. In retrospect, community mental health care of this era can be seen as inadvertently perpetuating stigma and as continuing to socialize people into disability. Many people with mental illnesses rejected this approach.

The search to improve community mental health care has steadily evolved. Over the past five decades, numerous ideas and voices have shaped this evolution. People who experience mental illnesses, their families, mental health professionals, policy makers, administrators, insurers, theorists, advocates, judges, guild organizations, for-profit industries, media, public safety officials, and researchers are among those who have expressed views. The voices have often been conflicting and discordant rather than unified and clear (Banton et al., 1985; Levine, 1981). Consensus has rarely been achieved. And when consensus has developed, the instantiation of new models of care has often been characterized by rhetoric, inadequate funding, and failure, rather than by genuine commitment, faithful implementation, and success (Drake and Essock, 2009; Geddes and Harrison, 1997).

Some ideas have been validated by scientific evidence; many remain largely untested. Nonetheless, ideas have strongly influenced

the mental health service system and the field of community mental health. Several of these notions are discussed in detail throughout this text. Among the most prominent are the following:

From ethical and legal perspectives, people who experience mental illnesses have the same rights as others in society—the same rights to pursue their own health care preferences, functional goals, and happiness as others (Davidson et al., 2009). Legal rights include not only freedom from abusive treatments but also freedom to live and receive services in the ‘least restricted environment’. They also include the right to be considered competent to make decisions about one’s life. These rights can be abridged only if the individual meets specific legal standards. Thus, communities, clinicians, and families can no longer decide that an individual is incompetent on the basis of ad hoc criteria.

From a philosophical perspective, people with an illness are considered ‘people first’. Neither illness nor disability determines personhood; humanity defines a person. Because an individual who experiences a mental illness should not be defined by the illness, current usage prefers language such as ‘a person who has experienced mental illness’ or ‘a person with schizophrenia’ rather than ‘a schizophrenic’.

From a clinical perspective, community mental health now assumes that people with even the most severe mental illnesses have a significant capacity to manage their own illnesses and to pursue personally meaningful goals, often in spite of ongoing symptoms (Mueser et al., 2002). Current mental health philosophies and interventions thus emphasize strengths, resilience, self-management, self-agency, and capacity for functional recovery.

From a socioenvironmental perspective, the strengths of the individual’s social network and community are also more salient (Warner, 2000). The professional view of families has transitioned from causing illness (schizophrenogenic mothers) to exacerbating illness (high expressed emotion), to ameliorating illness (families with a member who experiences mental illness). Many families can provide considerable supports to their relatives who are experiencing mental illnesses, especially when the families themselves are helped to acquire appropriate education, skills, and supports. Similarly, the community environment is now viewed as a potential salutary force. Like the rest of us, people with mental illnesses grow and mature through participating in regular jobs, educational experiences, integrated social settings, normal housing arrangements, and routine community activities (Becker and Drake, 2003). In addition, we recognize that the public’s misperceptions about mental illness can be extremely damaging and can be overcome by direct contacts and community integration (Thornicroft, 2010).

From a psychological perspective, as Alcoholics Anonymous and religious communities have long recognized, helping others promotes and enhances the process of recovery from a major illness. Peer supports and clients as mental health employees have become prominent features of the mental health system in many areas (Solomon, 2004). Although lacking controlled research, these movements continue to grow steadily and to be supported by numerous personal testimonies.

From a research perspective, community mental health continues to move steadily toward becoming a scientific practice. Beliefs in the mysteries of psychotherapy, untested theories and interventions, and the authority of senior clinicians and professional

societies have gradually been replaced by scientific methods. While many interventions have been proven ineffective or harmful, an increasing number of interventions have been shown to be efficacious and many have also been shown to be effective in real-world settings (New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999). Research standards, transparency, and unbiased review processes have enabled progress. Evidence-based medicine and evidence-based practices have largely replaced the acceptance of outpatient mental health as a cottage industry with few standards. Debates continue regarding what outcomes to study, appropriate research methods, and the emerging efforts to study service systems.

From a systems perspective, research on unmet needs has also expanded considerably (Thorncroft, 2000). Despite increased knowledge of effective clinical interventions for most mental disorders, the gap between science and service remains large. Most of the people who experience mental disorders are unable to access effective treatments, even in the wealthiest countries (Mojtabai et al., 2009). When access is not a problem, acceptability often is—many people reject the services that are offered (Kreyenbuhl et al., 2009). Further, most mental health practitioners and systems do not use the most effective practices (Drake et al., 2009b). Continuing education programmes typically do not result in learning and using new skills. Information systems do not deliver useful point-of-contact information that would enhance collaborative decision-making. Finally, mental health treatment systems typically do not track quality of care and outcomes. Information systems for mental health often record amounts of services delivered rather than the quality or outcomes related to those services.

From an international perspective, as globalization, migration, and cultural pluralism transform the world, community mental health systems have not responded adequately to the challenges afforded by these trends. People from minority cultures and those who speak other languages have difficulty accessing services that they find welcoming and acceptable. Disparities in mental health services affect virtually every country (Desjarlais et al., 1995; Thorncroft et al., 2010).

The structure of this book

We have organized this book to reflect the large diversity of perspectives on community mental health but also to attempt a synthesis of perspectives and our convergence of views. Across two countries (the United Kingdom and the United States) and over several decades of working in, studying, and thinking about community mental health, we share a remarkable convergence of ideas.

Community mental health should respond to the needs, goals, and preferences of people who experience mental illnesses. Following a brief introduction (Chapter 1) and historical review (Chapters 2 and 3), the book provides overviews of recovery as a central organizing vision in community mental health (Chapter 4) and of the needs for a community mental health system (Chapters 5–10). We begin with the epidemiological data that underlie a public health approach to community mental health. People are not merely numbers, of course, and Chapter 8 includes the perspectives of those who experience mental illnesses themselves. Because we are concerned with social justice, we emphasize the needs of specific groups, such as ethno-cultural minorities and immigrants,

which are often overlooked in establishing mental health services (Chapters 10 and 11).

Specific components of community mental health and how they are organized constitute the heart of community mental health. They are discussed in Chapters 12 to 24.

Ethical and legal perspectives, including the difficult issue of coercive interventions, are discussed in Chapters 25 to 27.

Countervailing the recovery vision are public attitudes that can be characterized as stigma and discrimination. These issues and efforts to overcome them are discussed in Chapters 28 to 30.

Mental health policies and financing mechanisms determine the structure of potentially available services. Chapters 31 to 33 cover these issues.

Within the parameters of governmental policies and funding, professionals are responsible for implementing a service system that is as effective as possible. Chapters 34 to 38 discuss the mechanisms used to ensure effective care, in low- and middle-income countries as well as wealthy ones.

Intervention science—how we know what interventions and services are effective—is another critical building block for a community mental health system.

Finally, we consider the future of community mental health, again across the broad spectrum of countries, in Chapter 43.

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The National Mental Health Care Program in Poland for 2017–2022 increases the role of community psychiatry in psychiatric care. This requires adequate changes in teaching curriculum for universities in Poland. The primary aim of presented study was to assess the medical students' opinion and their state of knowledge about community psychiatry. Students of medical fields of studies (mostly medicine and nursing) and psychology (N=171) from different universities in Poland were tested. Community psychiatry was found as a valid alternative to conventional form of psychiatric care by majority of st

Mental Health Care in Settings Where Mental Health Resources Are Limited: An Easy-Reference Guidebook for Healthcare Providers in Developed and Developing Countries. Copyright © 2014 Pamela Smith. All rights reserved. Preface & Acknowledgements v Medical abbreviations list vi Introduction vii (Purpose of the Guide vii; Using of the Guide viii). PART I: Mental Health Worldwide 11. In communities where little or no mental health care exists, people with mental conditions are at risk for increased illness, stigma, and abuse. Their fundamental right to mental health & happiness can be compromised.