EDITORIAL

Mistakes to avoid in the implementation of community mental health care

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In this issue of the journal, we publish the first WPA guidance produced as part of the WPA Action Plan 2008-2011 (1,2), dealing with steps, obstacles and mistakes to avoid in the implementation of community mental health care. Two further documents are almost ready and will soon appear in the journal: the WPA guidance on how to combat stigmatization of psychiatry and psychiatrists, and the WPA guidance on mental health and mental health care in migrants.

The guidance we present in this issue can be regarded as a "second-generation" document in the area of community mental health care, because it takes advantage of the experience of the countries in which the development of community care has been most active, to point out not only what should to be done to implement the process, but also the errors which should not be repeated.

In this latter respect, the document contains several important statements, which I will now list and discuss briefly.

A balanced care model

The guidance affirms unambiguously that our objective should not be the complete, although gradual, shifting from hospital-based to community-based psychiatric care, but "the reform of mental health services according to an evidence-based approach, balancing and integrating elements of both community and hospital services". We have learnt from experience that public hospital beds are necessary in psychiatry (i.e., it is not true, as sometimes asserted, that "psychiatry does not need any beds"). While community mental health care is developed, the dignity and quality of hospital care must be secured. Hospital and community services have to be integrated, in order to ensure continuity of care, and the general hospital should be a place where psychiatry actively interacts with other medical specialties.

Preserving psychiatrists' clinical skills

The guidance states explicitly that there is a need to "cultivate psychiatrists' clinical skills, so that they are preserved in spite of the variety of new commitments". A psychiatrist who has become a first-class expert in furnishing residences in the community, but is not able to diagnose an organic psychosis or to plan the treatment of a girl with anorexia nervosa, should not be proud of himself. In order to be really useful to the community (and to other professionals, whom they are supposed to train), psychiatrists have to bring to the community their clinical expertise. The practice of community care will certainly enrich psychiatrists' skills, but the new skills will have to be added to the traditional ones, not to replace them.

Avoiding an exclusive focus on psychotic conditions

The guidance mentions, among the "issues that may compromize the integrity of community based services", "an exclusive focus on psychotic conditions, so that the vast majority of people with mental disorders are neglected or dealt with by professionals who do not have the appropriate expertise". A community mental health service with an identified catchment area whose human resources are almost exclusively used to address all the needs of twenty or thirty chronic psychotic patients, while all other people with mental disorders in the catchment area are even not aware of the existence of the service, is not really fulfilling its mandate. The appropriate resources and synergies must be developed in order to ensure an adequate coverage of the whole range of mental disorders existing in the community.

Protecting patients' physical health

The guidance is probably the first of its kind to highlight the neglect of patients' physical health as an issue which may compromize the integrity of community based services. Indeed, the fact that professionals of a community service are not motivated to deal with physical problems of their patients, or that the service is far away from any hospital, is not a good reason to allow deterioration of patients' physical health. The appropriate synergies with general practitioners in the relevant catchment area must be developed. Furthermore, the fact that antipsychotic medications are not regarded by the staff of the service as the most essential ingredient of care is not a good reason to use them irrationally or to ignore currently available guidelines aimed to prevent and address their side effects.

An evidence-based approach

The guidance repeatedly emphasizes the need for an evidence-based practice in the community. Indeed, the develop-

ment of community care is often driven by passion and enthusiasm, but passion and enthusiasm are not sufficient to manage mental disorders. These disorders require evidence-based interventions, which must be available in all community mental health services. Community care cannot be a continuing, unlimited experiment (and experimentation has its rules, which should apply also to this case). Furthermore, it should be clear that community care "can allow treatment to be offered to a patient, but is not the treatment itself" (3). What is actually done in the community is not a marginal issue; it is the essence of the problem.

Avoiding linkage of mental health care with narrow political interests

The guidance affirms that "a common mistake is linking inappropriately the reform of mental health care with narrow ideological or party political interests". This bold statement, which appears for the first time in a document of this kind, will certainly be welcome by many psychiatrists. Ideological fanaticism has been, in fact, in several countries a major source of derailment of the process of development of community care and of division of the mental health movement.

The need for a carefully considered sequence of events

The guidance emphasizes the need for "a carefully considered sequence of events linking hospital bed closure to community service development". Indeed, it is not uncommon that hospital-based services are closed without sustainable alternatives in the community. The transfer of chronic patients from a very "visible" public mental hospital, which *must* be closed, to "invisible" (and uncontrolled) private facilities has been unfortunately a not rare modality of deinstitutionalization. For thousands of other people, as repeatedly reported in the literature, the landing place has been a street or a prison.

Long-term planning is essential

The guidance clearly and repeatedly points out that the implementation of community mental health care requires a strong and continuing commitment by the relevant administrations, and that planning (including investments in terms of facilities, staff and training) should be made on a long-term basis. Furthermore, a long-term monitoring of the process is essential, and such indicators as suicide rates, family burden and mental health problems in prison populations should be continuously evaluated, in addition to patients' clinical outcomes, perceived quality of life and satisfaction with care.

The importance of psychosocial rehabilitation and social inclusion

The guidance repeatedly mentions psychosocial rehabilitation and social inclusion of people with mental disorders as crucial aspects of community mental health care. Having transferred a chronic patient from a mental hospital to a residence in the community, where he will stay forever, is not sufficient, if the patient is left there with just a minimal basic assistance.

Empowerment of families is a priority

The need to involve carers, as well as users, in the process of development of community mental health care is repeatedly emphasized in the guidance. Indeed, it has happened too often that families of discharged patients with severe mental illness have been left alone with their problem, without any kind of practical and emotional support. Overlooking or minimizing this issue is unjust and dishonest, especially since evidence-based family interventions are now available and have been proved to be effective.

The WPA supports the development of community mental health care worldwide, so that people with mental disorders can have services available as close as possible to their locality, can be treated in the least restrictive environment, and can maintain their links with the community. We expect the implementation of community mental health care to improve patients' clinical outcomes, perceived quality of life and satisfaction with care. On the other hand, there are lessons we have learnt from the experience of those countries in which the development of community care has been most active in the past few decades. By this guidance, the WPA intends to bring these lessons to the attention of psychiatrists (as well as other professionals and policy makers) of countries in which the process has just started or is going to start in the near future.

References

1. Maj M. The WPA Action Plan 2008-2011. World Psychiatry 2008; 7:129-30.
2. Maj M. The WPA Action Plan is in progress. World Psychiatry 2009;8:65-6.
3. Thornicroft G. Testing and retesting assertive community treatment. Psychiatr Serv 2000;51:703.