
EU COMPASS FOR ACTION

ON MENTAL HEALTH AND WELL-BEING

PROVIDING COMMUNITY-BASED MENTAL HEALTH SERVICES

POSITION PAPER

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1. Introduction

1.1. Community based mental health services as a priority in the European Union

The last fifty years have seen one of the greatest international social movements of all time - the closure of large institutions and the development of community based services for people with mental health problems. Although many factors have been suggested as fuelling this process, one major driver was a change in society's attitude towards people with mental illness, away from exclusion and marginalisation towards inclusion and participation. Alongside this humanitarian shift in mental health care, research has helped to identify the most effective interventions, understand how to deliver them, and shaped the development of community services further.

The process of deinstitutionalisation is strongly supported by international policy but implementation of community based mental health care is patchy and many barriers impede progress¹. The European Commission recognised the need to prioritise mental health through the Joint Action for Mental Health and Well-being² funded by the EU Health Programme from 2013- 2016 which attempted to address these obstacles by supporting EU-countries to review their policies and share experiences in improving mental health policy, efficiency and effectiveness.³

1.2. Explanation of the issue

In many low and middle-income countries (LMIC), mental health care provision remains limited to a small number of large, overcrowded institutions that are under resourced and inefficient. However, there is no room for complacency in more 'deinstitutionalised' countries, where there have been reports of reinstitutionalisation or 'transinstitutionalisation' of those with more complex mental health needs (Priebe et al., 2005). The EU report on longer term mental health care specifically focussed on how to overcome the barriers to successful implementation of community mental health care for this group (Caldas de Almeida and Killaspy, 2011).

Values

Human rights organisations have played a major role in driving the process of deinstitutionalisation globally, calling attention to violations of patients' human rights and clarifying the ethical and values based arguments for community based mental health care. These include: the right to the highest attainable standard of physical and mental health and 'parity of esteem' between the two; the right to liberty and security; the right to non-discrimination; and protection against inhumane and degrading treatment. Over time, issues of capacity and informed consent have also been incorporated into mental health legislation in many countries. The right to the highest attainable standard of physical and mental health is particularly important, including:

¹ The EU Member States are responsible for the definition of their health policy and for the organisation and delivery of health services and medical care (Article 168, Treaty on the Functioning of the European Union).

² Please find more info available at <http://www.mentalhealthandwellbeing.eu/>

³ The Joint Action resulted in the "EU Framework on mental health and well-being"; https://ec.europa.eu/health/mental-health/framework_for_action_en

- Access to appropriate services
- The right to individualised treatment
- The right to rehabilitation and treatment that promotes autonomy
- The right to community-based services
- The right to the least restrictive services, as close to home as possible
- The protection of human dignity
- The provision of support to the person's family/informal carer network

Key principles for deinstitutionalisation

In order for the process of deinstitutionalisation to progress successfully, there has to be high level agreement to prevent inappropriate new admissions to the institution and to discharge long-stay patients to appropriately supported accommodation in the community. In order to achieve this, clear political support is required (for example through an explicit mental health policy) and investment of adequate resources to develop well co-ordinated community based services provided by multiple agencies. Good collaboration between ministries and statutory agencies (health, social care, housing, judiciary, education) and NGOs that provide services is critical.

1.3. Scope of this report

Community mental health systems in context

The development of community based mental health care has progressed at different rates in different countries. This is strongly influenced by resources; countries that are more economically developed have tended to be at the forefront of developing and evaluating the impact of new models of care. However, as research in this field has progressed, there has been increasing recognition of the importance of context in understanding the effectiveness of different models. This includes differences in the allocation of resources to mental health care at the national or regional level, as well as differences in the sociocultural context. Clearly, the full range of specialist community based services cannot be implemented in less economically developed countries, but not all models of care are appropriate in different settings. Thornicroft and Tansella (2003) have described a 'balanced care model' that provides guidance on key components of community based mental health care that might be expected to be provided in countries with differing levels of economic development. This includes ongoing provision of some inpatient beds alongside the development of community based services (Thornicroft and Tansella, 2013). Where possible, we have included in this report examples of adaptations of service models that have evolved through the need to respond to contextual influences.

Effectiveness of models of mental health care that deliver evidence based interventions

The development of effective pharmacological agents for mental illness in the 1960s was an important accelerator of the deinstitutionalisation process. Over recent decades, researchers have also turned their attention to developing and evaluating the most effective ways to deliver mental health care. These include improving the quality of inpatient units, the development of increasingly

specialised community teams (including those that provide short term home based support to people in mental health crisis, other alternatives to hospital admission, teams that focus on people developing mental health problems and teams that focus longer term on those with more complex needs), the development of psychosocial care (such as supported accommodation and vocational rehabilitation), and the increasing participation of users and families in the improvement of policies and services. This report presents a summary of what is known so far on the most effective approaches.

1.4. Methodology

Data presented in this report is derived from a number of sources:

- A survey among Member States from the EU Compass for Mental Health and Wellbeing
- A literature review of research papers, published in peer-reviewed journals, investigating community mental health care systems, models of care and interventions, and service user outcomes and cost-effectiveness (conducted in October, 2017).
- Publications from the World Health Organisation (WHO) mental health evidence and research (MER) team.

The retrieved data has been synthesised to provide a critical and up-to-date review of the available evidence.

2. Community-based mental health services – The situation in Europe

The promotion of deinstitutionalisation has been ongoing for many decades. Recent analysis shows between half to two thirds of European Member States have progressively decreased the number of beds in mental hospitals and closed some of them (Caldas Almeida et al., 2015; Samele et al., 2013). Countries such as Italy and Sweden have gone further by having no psychiatric hospitals, but rather psychiatric units based within general hospitals. For countries where institutional care remains, implementing a programme of deinstitutionalisation has been problematic, even where a strategy or programme to do this has been developed (Samele et al., 2013).

Part of the deinstitutionalisation process involves downsizing or closing mental hospitals entirely. For some countries this has resulted in a steady or significant decline in the number of psychiatric inpatient beds, however, for others this number has increased (Caldas Almeida et al., 2015; Samele et al., 2013). As mentioned earlier, there is some evidence that many people have simply been moved from one form of institution to another (Priebe et al., 2005). However, although one recent study found an association between the decline in psychiatric beds and an increase the number of forensic beds and prison populations in 11 European countries, this association disappeared after controlling for gross domestic product (Chow et al., 2016).

It is important to recognise that whilst the development of community-based mental health services is obviously a mainstay in the deinstitutionalisation process; this does not mean the complete eradication of inpatient services. A balance in the provision of mental health services across primary care, secondary community mental health care, outpatient and inpatient care in district general

hospitals and more specialist inpatient mental health units is required to ensure a comprehensive and responsive system. Where needed, inpatient beds for people in acute mental health crisis should be provided in district general hospitals or local community mental health centre/units (but please see later section on alternatives to acute inpatient care as well). Longer term inpatient beds that specialise in rehabilitation of those with more complex needs should also be provided in community mental health centres/units or separately in stand-alone community based rehabilitation units, with the aim and expectation of patients moving on to supported accommodation in the community. No inpatient service should operate as a 'home' for people with mental health problems, even those with longer term and complex needs. Provision of adequate supported accommodation is therefore also a key component of a system that can respond to the differing levels of needs of service users over time. (McDaid & Thornicroft, 2005; Gater et al., 2005; Thornicroft & Tansella, 2013).

A WHO survey of 42 countries identified a number of successful paths to deinstitutionalisation (WHO, 2014). One of the most important elements was political support and skill in the appropriate timing of mental health reform. Other drivers included support from the majority of mental health professionals for the changes, and adequate investment to develop community services alongside the closure of large institutions, often before any capital can be released from the sale of the buildings.

Determining the extent of community mental health care provision across Europe is difficult given the lack of robust/comparable data. According to one study almost all Member States report having primary mental health care and outpatient services, with around two thirds having mental health centres, but far fewer have specialist mental health services such as assertive outreach teams (Samele et al., 2013). Extreme variation in the number of mental health workers between countries has also been noted (WHO, 2014). Overall, the provision of community-based mental health services within EU countries is only partially developed (Caldas Almeida et al., 2015). The European Community based mental health service providers network (EUCOMS; www.eucoms.net), WHO Collaborating Centres for Research and Training in Mental Health (of Lille, London, Trieste and Verona), and other training centres (e.g., the Lisbon Institute of Global Mental Health) provide learning on how to implement community mental health services and their essential elements.

2.1. Financing community mental health systems and cost effectiveness

Community-based mental health care is no more costly than hospital-based care (Knapp et al., 2011). Some economic evaluations of deinstitutionalisation have found community care to be cheaper than institutional care systems (Beecham et al., 1996). However, it is important for policy makers not to expect costs to be lower for community-based services as this can lead to under investment in essential services that comprise a comprehensive and effective system (Knapp et al., 2011).

Reallocating resources away from mental hospitals and providing sufficient funding are fundamental to establishing community mental health care (Caldas Almeida et al., 2015). Once established, sustaining mental health budgets to ensure community-based services are adequately resourced is equally important. Of note, the economic crisis in 2008 has led to considerable cuts in essential services for young people and adults with mental health problems despite increasing demand (European Social Network, 2012).

Insufficient funding for mental health services is a recurrent issue and some authors have highlighted the need to improve both the effectiveness of healthcare and its cost effectiveness (Knapp & McDaid, 2007; Knapp et al., 2007). While it is important to implement cost-effective services and interventions it is also important to consider how best to distribute limited resources. This includes not only prioritising mental health services when the demand for them is likely to rise (e.g. during times of austerity) but also investing in evidence-based mental health promotion strategies at the population level (McDaid & Knapp, 2010). The tensions between these two aspects of mental health care need to be acknowledged in order to avoid unhelpful divisions in policy making and inequitable resource allocation.

The Research on Financing Systems' Effect on the Quality of Mental Health Care project (REFINEMENT) aimed to standardise and compare different systems of financing and performance of mental healthcare in nine European countries (McDaid et al., 2013). The need to contain healthcare costs has intensified and the study highlighted how some EU countries have adopted elaborate systems of service activity and performance assessment that are aligned with ongoing investment. There is now a greater understanding of the impact of different funding mechanisms for mental health care in different settings (e.g. public, private or hybrid funding systems) and their impact on patient pathways. These different funding approaches influence the organisation and governance of the mental health system and are highly specific to the context within which they operate. This makes it difficult to generalise findings from studies in one setting to other contexts.

In the last decade, newer models of community-based services have emerged. Some may be more expensive, but even these can be cost-effective if set up and managed appropriately, especially as they are likely to deliver improved outcomes (Knapp et al., 2011)

3. Models of care

3.1. Primary Care Liaison (PCL) and Collaborative Care (CC)

Despite the growth of secondary mental health services, general practitioners (GPs) remain an essential resource in the identification and management of mental illness in the community. Indeed, in less economically developed countries primary care is the mainstay for community based mental health care. In more economically developed countries with well-functioning primary care services, GPs are likely to assess and treat the majority of people presenting with common mental disorders such as anxiety and depression. Historically, however, a lack of specialist training and poor linkage between primary care and mental health services has led to poor outcomes for service users (Das, Naylor & Majeed, 2016). A number of service-level approaches have been implemented to overcome these obstacles.

Primary care liaison (PCL), or consultation-liaison, services aim to reduce unnecessary and premature transitions to secondary mental health services by providing professional support, assessment, triage, referral and, where indicated, low intensity psychological interventions (such as psychoeducation, online self-help, medication advice or self-management strategies). PCL teams are multidisciplinary and are typically based in GP surgeries in the community, receiving referrals from both health and social care practitioners. Although collaboration and consultative support is central to the work of PCL teams, responsibility for the service user is held by primary care professionals (e.g.

GPs); PCL workers do not offer caseload management services. The collaborative care (CC) model, an alternative form of PCL, shares the overall aims and structure of PCL, and offers similar services, however differs in that it includes a case management component (Mitchell, 2016).

The effectiveness of consultation-liaison services was assessed in a recent Cochrane review. The majority of included trials examined outcomes for depression, with the remainder examining a variety of presenting problems, including depression, anxiety, somatoform disorders, medically unexplained symptoms and alcohol misuse. Evidence suggests that this service model, when compared to standard care, is associated with improved patient satisfaction and treatment adherence for up to 12 months, and better mental health for up to three months, particularly for individuals with depression (Gillies et al., 2015). The evidence base for CC with high-prevalence disorders, such as depression and anxiety, is well developed, with several systematic reviews and meta-analyses demonstrating the superiority of this approach over standard care in reducing symptoms and improving treatment adherence and satisfaction with care, in the short, medium and medium-long term (Coventry 2014; Reilly 2013; Sighinolfi et al., 2014; Thota, 2012). However, the evidence is more limited with regard to its efficacy with more severe presentations (Reilly et al., 2013).

3.2. Mental health teams

Community Mental Health Teams (CMHT)

Community mental health teams (CMHTs) are a core component of non-hospital based support for individuals with severe mental illness (SMI). CMHTs are multidisciplinary teams, typically comprising psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists and, increasingly, peer support workers, that provide specialised assessment and interventions to service users with a range of more severe needs of care (most commonly to individuals with mental health problems such as psychosis, bipolar affective disorder, severe depression and personality disorder). Importantly, CMHTs operate within a defined geographic locality (catchment area) which increases their accessibility to service users. These teams usually organise their work through generic case management, whereby each team member has a specific caseload of service users that they work with, but the team has the capacity/capability to perform all functions required by specialist mental health services, delivering evidence based interventions and support. The presence of multiple disciplines in a team brings care closer to the patient and interdisciplinary team work challenges traditional professional boundaries (Nancarrow et al., 2013). In more developed community mental health systems, these teams will typically be supplemented by more specialist teams (see below).

During the expansion of community care, CMHTs became one of the primary models of community based treatment. As with many systems-based, complex interventions, and due, in part to their rapid implementation, randomised controlled trials (RCT) assessing the effectiveness of CMHTs are limited; the bulk of the evidence is descriptive. However, a synthesis of the available research indicates that, when compared with standard care (usually hospital based outpatient clinics where the client is seen by one professional, most commonly a psychiatrist), CMHT care is associated with lower admission rates, fewer deaths and increased service user satisfaction (Malone et al., 2010). CMHTs have also

been associated with better quality of care, when compared with traditional hospital based services, at two and four year follow-up (Gater et al., 1997).

Assertive Community Treatment (ACT) and Intensive Case Management (ICM)

Derived from the seminal work of Stein and Test (1980), ACT aims to sustain contact with severely ill, 'hard-to-engage' service users in the community, reduce hospital admissions and improve psychosocial outcomes by providing multidisciplinary team-based, flexible support, using an assertive approach to engagement. The ACT model has been carefully defined, with several fidelity measures available (Vanderlip, Cerimele & Monroe-DeVita, 2013). Core features include 'in vivo' client contacts (at the person's home or elsewhere in the community), a low client-staff ratio, continuous coverage (including the capacity to respond to crises 24hrs per day), a shared team based caseload (rather than individual case management) and long-term care (Bond & Drake, 2015). The focus is on assisting the person to manage their illness through psychosocial interventions and medication management alongside practical support. Representing a similar approach to ACT, intensive case management (ICM) also provides long-term, community-based care for people with SMI, however, in ICM, practitioners are responsible for small, individual caseloads (cf. the team caseloads of ACT). These assertive approaches to community care are widely implemented; as highlighted in a recent review by Vijverberg and colleagues (2017), 22 out of 42 countries in Europe have policies and/or legislation requiring access to ACT, or equivalent services, for individuals with severe mental illness (WHO, 2008).

Numerous RCTS have been conducted assessing the effectiveness of ACT compared to standard care. Initial investigations, across the USA and Australia, demonstrated significant reductions in hospitalisations and associated costs, better engagement and client satisfaction (Marshall & Lockwood, 2000). However, in the UK, studies failed to replicate the positive outcomes in terms of reducing hospital admissions and costs of care. A subsequent meta-analysis clarified that ACT is particularly effective in areas where there is a greater supply of inpatient beds and the comparison intervention is substantially distinct from ACT in terms of practice (Burns et al., 2007). For example, the REACT study (Killaspy et al., 2006; 2009), compared ACT to standard CMHT support; at both 18- and 36-month follow up, no significant differences in total inpatient days, other clinical or social outcomes or adverse incidents were observed between the ACT and CMHT participants. This was explained, in part, by the overlap in approach and function of ACT and CMHTs in the UK setting.

Similar conclusions have been drawn with regard to ICM; a Cochrane review (Dietrich et al., 2017) demonstrated that, compared to standard care, ICM was associated with reduced hospitalisations, increased patient retention and improved social functioning, however, when compared with analogous non-ICL approaches (larger caseloads), these advantages disappear. Therefore, the effectiveness of both ACT and ICM, and indeed most community mental health care interventions, appears to be dependent on context; these models can effectively reduce hospital admissions and the associated costs in settings where standard community services are underdeveloped or under-resourced.

Early Intervention Services (EIS)

Schizophrenia and other forms of psychosis are characterised by functional disability and high rates of relapse. Full remission is possible, however this becomes less likely after multiple psychotic

episodes and/or a delay in receiving adequate treatment. Early intervention services (EIS) aim to ameliorate the individual and economic consequences of psychotic illness through the early identification of individuals at high-risk of developing psychosis, or those in the early stages of the illness (the pro-dromal phase), and the provision of evidence-based treatment based on 'clinical staging', wherein the selection of interventions (pharmacological, psychological and social) are informed by illness progression (Marshall & Rathbone, 2011; McGorry, Killackey & Yung, 2008). Since the initial development of the service model, EIS have been implemented widely in Australia and Europe. However, due to differences in local resourcing and contexts, a number of variants have arisen: the specialist model, a multi-disciplinary, locality-bound team, offering time-limited ICM to individuals with first-episode psychosis (FEP); the 'hub-and-spoke' model, where a central 'hub' provides supervisory, training and administrative support to specialist staff embedded in local CMHTs; and, the 'integrated' model, where specific CMHT staff are nominated as EI workers and adopt a case-load of service users with FEP (Behan, Masterton & Clarke, 2016). The majority of research, however, has focussed on specialist EIS models.

Although there is, at present, inconclusive evidence to support intervention with individuals presenting with prodromal symptoms (Marshall & Rathbone, 2011), data generally supports the efficacy and cost-effectiveness of the specialist EIS model. Reviews indicate that EIS improves engagement with services, and reduces admission rates, symptoms and relapse (Bird et al., 2010). A number of methodologically rigorous RCTs, including the OPUS (Denmark; Bertelsen et al., 2008) and LEO-CAT (UK; Craig et al., 2004) trials, have demonstrated the superiority of EIS in reducing relapse, readmissions and symptoms, when compared to standard care. However, some queries have been raised regarding the stability of the observed clinical improvements; for example, the 2-year outcomes of the OPUS trial were not sustained at 5-year follow-up (Bertelsen et al., 2008). However, the longitudinal Treatment and Intervention in Psychosis (TIPS) study found higher rates of functioning and milder deficits amongst EIS service users, compared to non-EIS service users, at 10-year follow up (Hegelstad et al., 2012). Importantly, EIS are highly valued by both service users (Lester et al., 2012) and carers (Lavis et al., 2015), and economic evaluations of EIS in the UK (McCrone et al., 2010), Italy (Serretti et al., 2009), Denmark (Hastrup et al., 2013) and Sweden (Cullberg et al., 2006) have confirmed the cost-effectiveness of this model of care.

Community rehabilitation teams

Community rehabilitation teams offer multidisciplinary support to individuals with complex and enduring mental health problems and their carers. Service users will often have undergone lengthy psychiatric admissions and may present with treatment-resistant psychosis and co-morbid conditions such as cognitive-impairment or challenging behaviour (Mountain, Killaspy & Holloway, 2009). Evidence-based, psychosocial interventions are provided in the community, typically focussing on improving social, vocational and occupational outcomes, and aim to support individuals to achieve both personal recovery and increased independence. Teams emphasise therapeutic optimism and, with an awareness of the nature of presenting problems, will often work with individuals for an extended period of time.

It is difficult to ascertain the exact prevalence of this service model across Europe; the majority of EU member states have policies that require the provision of community-based rehabilitation services,

though, in reality, there is limited access and the exact configuration of these services is unclear (WHO, 2008). In England, during a period of expansion, many community rehabilitation teams were simply rebadged as assertive outreach teams in order to satisfy competing policy implementation requirements. There is evidence, however that these services are now returning to a more focussed community rehabilitation approach, mainly supporting individuals through the supported accommodation pathway (see below). Unfortunately, effectiveness data is also lacking; community rehabilitation teams are often discussed when examining the effectiveness of other accommodation-based services (e.g. Abrahamson, Leitner & Sasan, 1995; MacPherson & Butler, 1999; Kavanagh & Lavelle, 2008) or a 'rehabilitation services' more broadly (including inpatient and community supports) (MacPherson et al., 2002; Bredski et al., 2011), and, due to research design, it is not possible to isolate their effects.

3.3. Alternatives to inpatient treatment

Evidence indicates that inpatient treatment for psychiatric disorders is an expensive and often unnecessary method of intervention (Crisp, Smith & Nicholson, 2016), which is experienced by some service users as intrusive, unhelpful and unsafe (Katsakou et al., 2012). Various alternatives to inpatient treatment have been proposed, including crisis outreach and intervention in the community, day hospitals and short-term, residential, crisis houses.

Crisis intervention models / home treatment teams

Crisis intervention in the community aims to avoid, where possible, unnecessary acute inpatient admissions for individuals experiencing a mental health crisis, by providing outreach (home based) support in the community. Typically provided by crisis resolution and home treatment teams (CRT), or a variation of this model, these teams offer mobile, 24hr provision, rapid assessment, short-term, intensive multi-disciplinary support to service users in the community, and function as 'gatekeepers' to local inpatient beds (Wheeler et al., 2015).

Despite an overall lack of high-quality data, predominately due to the ethical and practical difficulties associated with recruiting and randomising participants during a psychiatric crisis, the available evidence indicates that CRT represent an effective and acceptable model of care. In one of the few RCTs in this field, Johnson and colleagues assessed the effectiveness (Johnson et al., 2005) and cost effectiveness (McCrone et al., 2009) of CRT intervention compared to standard care. Participants receiving CRT intervention were significantly less likely to be admitted to hospital eight weeks after initial contact and reported significantly higher satisfaction, when compared to those receiving standard care; costs were £2438 lower for the CRT group. Cohort studies in Norway, Spain and Germany also demonstrated reduced likelihood of admission (Corcoles et al., 2015) and significant improvements in clinical impairment, functional capacity (Hasselberg et al., 2011) and symptoms (Bechdolf et al., 2011; Kilian et al., 2016; Munz et al., 2011) in service users receiving CRT intervention. The cost effectiveness of this model has also been replicated (Kilian et al., 2016). An updated Cochrane review found that crisis intervention reduces repeat admissions and is more acceptable than standard care to service users and families (Murphy et al., 2012).

Day hospitals

Day hospitals, or acute day units, provide non-residential, intensive, time-limited treatment to service users experiencing acute psychiatric crises. Despite an initial growth in the implementation of these services in Europe throughout 1960s and 1970s, sparse evidence for their effectiveness and cost-effectiveness and the expansion of community based outreach services, contributed to a decline in their popularity (Marshall et al., 2011). However, with increasing budgetary constraints and ongoing pressures on inpatient services, day hospitals have again become a focus for policy-makers and researchers, as evidenced by the recently funded Acute Day Units as Crisis Alternatives to Residential Care (AD-CARE) study in the UK.

Much of the research relating to day hospitals is old, reflecting the early interest in this treatment model; in spite of this observation, a small number of more recent, methodologically sound studies have investigated their effectiveness. The European Day Hospital Evaluation (EDEN) study conducted a large, multi-centre RCT comparing the effectiveness of day hospitals and standard inpatient treatment, across five European countries (Germany, England, Poland, Slovakia and Czech Republic). No differences were found between patients using day hospital and those using inpatient treatment with respect to symptoms, treatment satisfaction and quality of life; day treatment was associated with greater improvements in social functioning at discharge, 3- and 12-month follow-ups, when compared to standard inpatient care (Kallert et al., 2007). Despite some variation in the nature of the findings, smaller, less rigorous studies from Germany, England and Canada found that service users accessing day hospitals demonstrated significantly greater improvement in symptoms, self-esteem and social participation during the intervention (Lariviere et al., 2011), and fewer symptoms at discharge (Priebe et al., 2006) and at follow-up (Liebherz et al., 2012), when compared to inpatients. A Cochrane review concluded that “acute day hospitals (are) as effective as inpatient care in treating acutely ill psychiatric patients” (Marshall et al., 2011, p.2).

Residential alternatives to inpatient admission

With an acknowledgement of the limitations of acute inpatient treatment, and the inappropriateness of crisis outreach services for some service users due to risk or other psychosocial factors, residential alternatives have grown in popularity in recent decades. There is large variation in the structure and staffing of these services, with models ranging from time-limited, community-based crisis houses (Slade et al., 2010) to family placements (Readhead et al., 2002).

Due to broad variation in terminology and service structures, research comparing specific models of residential alternatives to traditional inpatient treatment is sparse (Lloyd-Evans et al., 2009). The available evidence-base, while underdeveloped, suggests that patients admitted to community-based alternatives demonstrate clinical improvements, though these may be inferior to standard inpatient care; due to shorter admissions, however, these services may be more cost effective than traditional inpatient services (Slade et al., 2010). Readmission rates do not appear to differ between the two approaches (Byford et al., 2010), but qualitative investigations indicate that service users prefer residential alternatives over standard inpatient care (Osborn et al., 2010).

3.4. Housing and housing-related support (supported accommodation)

Housing-related support, or supported accommodation, operates as a component of the broader mental health 'care pathway' by providing focussed, flexible support to service users with more complex needs that prevent them living independently. In low and middle income countries and countries that have a more family orientated culture there may be less provision of supported accommodation services as service users tend to return to the family home on leaving hospital, even when their support needs remain high. Supported accommodation services aim to address service users' functional impairments by helping them to develop practical living skills, improve social functioning and promote recovery and independence. These services vary widely in physical structures, staffing, recovery focus and length of stay. Typically, a variety of supported accommodation services will be available, ranging from high-support, 24-hour staffed settings, to shared group homes with lower staffing levels, to independent tenancies with outreach support, where staff are based off site and visit service users in their own homes (Killaspy, 2016). Some services are structured in a continuum, whereby service users' progress from higher to lower supported settings as individuals gain skills and confidence to manage more for themselves. Others aim to house service users immediately in permanent accommodation and provide flexible, responsive outreach support (such as the 'Housing First' model).

A lack of high-quality trials, definitional issues and a broad variation in service models has made synthesis of the supported accommodation research literature challenging; a recent Cochrane review did not identify any studies that fulfilled their inclusion criteria for high quality trials. The strongest evidence comes from studies of the 'Housing First' model when focussed on homeless mentally ill populations, where a number of high-quality studies and a recent large RCT have demonstrated consistent effects on housing retention and stability and appropriate use of clinical services (e.g. McHugo et al., 2004; Wood et al., 1998; Aubry et al, 2016). However the characteristics of this group make it difficult to generalise these encouraging results to other populations. The evidence base for supported accommodation with other mental health service user groups is less developed; data suggest a trend toward reductions in hospitalisations over time, but mixed findings with regards to symptom severity, social functioning and quality of life (McPherson, Krotofil & Killaspy, in-press). Recent findings of a large scale prospective cohort study from the QuEST study (Killaspy et al., 2016), a project investigating the quality and effectiveness of supported accommodation services in England, indicated that successful move-on to less supported settings was associated with the service's recovery orientation. Further research is required to compare the effectiveness of different models of supported accommodation.

3.5. Employment support

Due to a combination of reduced functioning, discrimination and stigma, individuals with mental health problems experience high rates of unemployment. Historically, this was addressed through sheltered employment schemes, or lengthy pre-vocational training, which aimed to provide individuals with the necessary skills to prepare them for paid employment in mainstream work settings. More recently, evidence suggests that the 'place-and-train' model of supported employment, specified as Individual Placement and Support (IPS), where individuals are assisted to

obtain paid, competitive employment as quickly as possible and ongoing support is provided to assist them to maintain their job, may lead to better outcomes.

In a synthesis of available RCT evidence, a recent Cochrane Review found that, compared to other vocational interventions, supported employment increases the length and tenure of competitive employment, and is associated with a shorter period to first employment, amongst people with mental illness (Kinoshita et al., 2013). These findings have been supported by a more recent meta-analysis (Modini et al., 2016). A multisite, pan-European study (England, Germany, Italy, Switzerland, The Netherlands and Bulgaria) comparing IPS to train-and-place vocational interventions, found that, for individuals with longer term severe mental illness, IPS outperformed standard vocational services across all vocational outcomes; twice as many IPS participants accessed employment, and this group were significantly less likely to be hospitalised during the follow-up period (EQOLISE; Burns et al., 2009). Similar outcomes have been reported in Sweden (Bejerholm et al., 2015) and Switzerland (Hoffmann et al., 2012, 2014). RCT evidence also indicates significant improvements in non-vocational outcomes, such as quality of life and occupational engagement in participants receiving IPS, when compared to those utilising traditional vocational rehabilitation services (Areberg, Bjorkman & Bejerholm, 2013).

Despite these positive outcomes, IPS does not suit all service users and many countries continue to provide a range of different approaches to assist individuals in their vocational rehabilitation. The Clubhouse model has been established across the world since the 1970s, providing a co-operative approach where service user members co-run the service. Members are assisted to gain work skills and progress to time limited transitional employment posts to gain work experience before moving on to competitive paid employment. More recently, Recovery Colleges have become popular, particular in the UK and Australia, providing service user run courses in a variety of domains including life skills, mental health management and vocational skills. There are as yet no robust evaluations of outcomes for this approach.

3.6. Evolving Practice and adaptations of care

A singular emphasis on evidence-based models of community care can overlook the potential impact and importance of various emerging approaches. In the following subsection, we present examples of evolving practice that, due to difficulties relating to experimental design or their relative newness, have an underdeveloped evidence-base but represent promising advances in community mental health care.

Flexible ACT

A Dutch version of ACT is Flexible Assertive Community Treatment (F-ACT). The multidisciplinary F-ACT team works in a defined catchment area for all people with severe mental illness and can operate in two different ways:

1. Individual case management by a member of the team. Other disciplines can be involved based upon the needs of the patient.

2. Intensive (ACT) team care, which involves the clients having contact with several team members; these clients are listed on the Community Treatment board and the team discusses them every day to decide which form of care should be provided and by which team members.

For most clients, individual supervision (1) suffices. But if psychosis recurs (or threatens to recur), if hospitalization is imminent or if an individual needs extra care for some other reason, the care is stepped up (2). This is a fluctuating group of 10–20% of the clients in the team's total caseload. For these clients the team provides team care according to the ACT principle of 'shared caseload'. This means that all members of the team have been informed about the client and that he or she is monitored and counselled by several care workers in the team. As a result the client can receive care every day or even several times a day.

To ensure good coordination of the care workers' activities, there are daily meetings to discuss clients on the Community Treatment board. If individual supervision is not enough and more intensive care is required, the client's name is listed on the board during the team's meeting. The clients on this board are discussed every day. Partly this group can be recognized as the group for Stein and Test's ACT model (focused on the most vulnerable 20% of people with severe mental illnesses). This group consists of a high percentage of people with psychotic disorders, usually combined with addiction problems (dual diagnosis). Many of them had been in hospital (sometimes for a long time) and were caught in the 'revolving door' between the hospital and the community.

The Flexible model has not been tested in an RCT. There are however several observational trials, performed in the Netherlands, England and Sweden, indicating that the model is effective, feasible and attractive for professionals (Bak et al., 2007; Drukker et al., 2008; Firn et al., 2016; Firn et al., 2013; Lexen & Svensson, 2016; Nugter et al., 2016; Van Veldhuizen, 2007)

The model is widespread in The Netherlands, where a model fidelity was developed: the FACT scale (FACTs). This scale was developed by the CCAF (Certification Centre for ACT and Flexible ACT), a non-profit foundation set up by Dutch mental health care professionals and researchers (<https://ccaf.nl>). The CCAF has certified over 300 Flexible ACT teams. The certificates assure organizations, family representatives and mental health care purchasers of the quality provided by these teams.

Recovery-based practice

Emerging from the psychiatric consumer/survivor initiatives of the late 1980s, the recovery movement, and its associated principles, have become central to mental health practice and policy in most Western settings. Traditional conceptualisations of clinical recovery, specifically symptom remission and a return to pre-morbid levels of functioning, are now typically complemented by an emphasis on personal recovery, defined by Anthony (1993) as "...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p.527). The broader notion of the 'recovery model' includes both the subjective experiences of the services user and the establishment of recovery-oriented services (Warner, 2010). However, due to the complex and multidimensional nature of this concept, implementing practice guidelines to reflect the underlying philosophy, and designing appropriate empirical investigations into their effectiveness have been challenging.

Despite a multitude of measures that assess the recovery-orientation of services (see Williams et al., 2012), research suggests that there is persistent confusion amongst mental health staff as to the meaning of recovery and how it is, or should be, applied to clinical practice (Le Boutillier et al., 2015). A recent cluster randomised controlled trial sought to assess the effectiveness of a team-level intervention to increase recovery-supporting practice amongst CMHT staff in England (REFOCUS; Slade et al., 2015). Twenty-seven teams were randomly allocated to the intervention or control arms, and follow-up data was collected for 297 service users. At one year follow-up, no differences were found between the groups on service user self-reported recovery, or on staff knowledge, skills or attitudes. However, higher levels of team participation (attendance and engagement) were associated with greater recovery-promotion behaviour change and service-user interpersonal recovery (Slade et al., 2015). In a national study of inpatient rehabilitation services in England, that focus on individuals with more complex mental health needs, the recovery orientation of the service was found to be associated with successful community discharge at 12 month follow-up (Killaspy et al., 2016). Similarly, in a further national research programme that focussed on mental health supported accommodation services, recovery orientation of the service predicted successful progression to more independent supported accommodation (Killaspy et al., 2017). In both these studies, recovery orientation was assessed using a standardised measure of service quality (the Quality indicator for Rehabilitative Care; Killaspy et al., 2016).

Shared decision making / collaborative care-planning

Traditionally, care planning and decision making in mental health have been the sole responsibility of clinicians. The recovery movement, and its emphasis on self-determination and empowerment, has promoted active collaboration between professionals and service users across all aspects of care; it is argued that, as recovery is a fundamentally personal process, individuals must be empowered to define and direct their own treatment and support. This stance has been formalised in the 'Salzburg statement on shared decision making', a position statement from 58 experts from 10 countries affirming the role of the patient in healthcare decisions (Salzburg Global Seminar, 2011), in mental health policy (e.g. NICE, 2011) and in ethical and professional standards across a number of European countries (see Coulter et al., 2015). Person-centred care, collaborative care planning and shared decision making (SDM), while differing slightly in their focus, share a number of similar characteristics: active collaboration between clinicians and patients; decision support (including consideration of likely outcomes and uncertainties); and evidence-informed, and patient preference-informed, selection of assessments, treatments and care packages. It is argued that these approaches can improve both clinical and subjective outcomes for service users.

Despite the broad acceptance of these principles, formal implementation of collaborative care planning and SDM in European mental health systems has been limited, due in part, to the underdeveloped evidence base and attitudinal and organisational barriers (Bee et al., 2015; Coulter, 2017; Coulter et al., 2015; Slade, 2017). Syntheses of research into SDM in mental health care has been limited by a lack of methodologically sound trials; two extant reviews have identified only two eligible RCTs in this area (Duncan, Best & Hagen, 2010; Joosten et al., 2008) and both concluded that the available evidence, while promising, did not warrant any firm recommendations. Recent commentaries, however, have argued that, in light of the more developed evidence base for SDM in

general health and long-term conditions (see Stacey et al., 2017 and Coulter et al., 2015) and the ethical imperatives of service user autonomy, beneficence and non-maleficence, the implementation of SDM in mental health care should be considered a priority (Coulter, 2017). There is also the importance of drawing on and utilising the service user's own expertise (Castillo & Ramon, 2017).

Peer support

In line with the recovery principles of self-determination and co-production, peer support interventions have become commonplace in many mental health systems. Though peer support can take on many forms, including mutual support groups, peer support services and peer mental health service providers (Lloyd-Evans et al., 2014), all models seek to use the lived experiences of current or ex-service users to model and promote recovery amongst individuals currently experiencing mental ill health. It has been argued that peer support can provide benefits for both the peer and the individual receiving support, typically in the form of personal empowerment, improved social networks, increased self-esteem, reduced self-stigmatisation and skill development (Faulkner et al., 2013).

Attempts to synthesise the developing evidence base for peer support interventions have been frustrated by variation in the characteristics of individual programmes and the poor methodological quality of available research. A recent review of meta-analyses and systematic reviews, however, concluded that peer services do not result in a reduction in the quality of provided care and are associated with equivalent clinical outcomes to traditional, non-peer delivered services (severity of symptoms and rates of hospitalisation) (Bellamy, Schmutte & Davidson, 2017). A number of reviews found that peer support interventions are more effective in influencing recovery-related outcomes, such as hope, empowerment and quality of life, than traditional clinical outcomes (Bellamy, Schmutte & Davidson, 2017; Chinman et al., 2014; Lloyd-Evans et al., 2014). Integration of peer workers into formal mental health services, however, must be executed with careful planning and an awareness of the potential risks for individuals; qualitative syntheses indicate that peer workers can experience negative attitudes, discrimination, prejudice and perceptions of a lack of credibility from other professionals, poor remuneration and difficulties managing their professional relationships with services users (Walker & Bryant, 2013; Vandewalle et al., 2016)

Personal budgets

Personal health budgets (PHBs) are designed to promote self-determination, and increase individual choice and control, by providing long-term mental health service users with a set amount of public money to be spent on personal health and social care needs. PHBs are not designed to replace standard care – in England, for example, access to primary, emergency and statutory mental health care is unaffected by a PHB allocation – but rather are intended to be used for 'additional' care or services that meet an individual's health and wellbeing needs, such as therapies, personal care and further education (Alakeson et al., 2016). Decisions around the use of PHBs are typically made in collaboration with clinicians, practitioners and carers, as appropriate (Hamilton et al., 2016).

A three-year evaluation of a PHB scheme in England found that, for individuals with mental health problems, overall costs decreased by 12% for those receiving PHBs, compared to an 8% increase for

those receive standard care. Overall, the PHB group also reported higher levels of care-related quality of life and psychological wellbeing (Forder et al., 2012). However, a more recent review found that, although the 15 studies included reported generally positive outcomes relating to choice, control quality of life, service use and cost-effectiveness, substantial methodological flaws limited their ability to be applied to policy decisions (Webber et al., 2014). Broader ethical concerns relating to the use of PHBs on non-evidence based treatments, wastage of resources, and their appropriateness for individuals with more severe problems who struggle to manage the administration required, have also been raised (Alakeson et al., 2016; Hitchen, Williamson & Watkins, 2015).

Tackling stigma and social inclusion

Stigma and discrimination are commonly experienced by individuals with mental illness. Hostility, exclusion and pervasive misconceptions regarding the causes and consequences of mental illness present a major obstacle to social inclusion for people experiencing SMI (Cobigo & Stuart, 2010; Davey & Gordon, 2017). These factors can result in unequal access to work and housing, and prevent full participation in social, cultural and political life. Indeed, social exclusion has been implicated as both a cause and consequence of mental illness, and is associated with poverty, isolation, disability and addiction (WHO, 2003). Attempts to reduce stigma and increase social inclusion for people with SMI have been implemented at the policy, population and individual level.

Anti-stigma interventions vary in structure, but are typically either educational (e.g. providing information about mental illness) or involve social contact with individuals with mental illness. Although the methodological quality of research in this field is generally poor, many systematic reviews and meta-analyses exist assessing the effectiveness of these interventions (e.g. Clement et al., 2013; Corrigan et al., 2012; Mehta et al., 2015). Broadly, evidence suggests that population-level approaches can generate short-term improvements in stigmatic attitudes and, to a lesser extent, knowledge, but not in behaviour, while social-contact interventions represent the most effective intervention in generating short-term changes in attitudes and knowledge (Thornicroft et al., 2016). The longer term benefits of these interventions remains unclear. While community mental health care itself is predicated on the idea of social inclusion, direct, research-informed interventions to reduce social exclusion are less common, and the evidence-base is underdeveloped. Recent projects, including the Connecting People Intervention (Webber, 2014) and the Community Navigator Study (Lloyd-Evans et al., 2017), aim to develop interventions to promote supportive relationships for people with mental health problems.

4. Implementation: Drivers and barriers

As stated by Medieros and colleagues (2008) “Deinstitutionalisation is... much more than moving people from one place to another” (p.20). The establishment of comprehensive, co-ordinated, effective and flexible community mental health care services is essential, both in facilitating the process of deinstitutionalisation, and in providing the appropriate levels of care and support for service users in the community. This process, however, is fragile, and is subject to a range of economic

and political factors. In the following section, we articulate some of the key drivers and barriers to the implementation of community based mental health care systems.

4.1. Drivers

Mental health policy and legislation

The WHO European Ministerial Conference on Mental Health in 2005 resulted in member states adopting The Mental Health Declaration for Europe and the Mental Health Action Plan for Europe, thus committing to the development and implementation of national, evidence-based mental health policies (Thornicroft et al., 2011; WHO, 2005a; WHO, 2005b). A clear national mental health policy is essential for the effective implementation of community mental health services, as it represents a formalisation of underlying values and principles, and guides the organisation, structure and availability of relevant services and programmes. At a minimum, mental health policies should outline plans for: limiting the use of psychiatric hospitals; developing community mental health services; integrating mental health services into primary care; and, promoting self-care (WHO, 2007). The optimal combination of community mental health services will be dictated by local context, population need and the availability of resources.

While most European states now have an established mental health policy (83% in 2011; Semrau et al., 2011), there remains some variation to which these policies have been implemented (see Winkler et al., 2017). Poor implementation can be a result of limited policy dissemination, under-resourcing, a lack of competent workforce or low relative priority of mental health compared to other political agendas (Omar et al., 2010); whatever the cause, without effective implementation, even the most comprehensive mental health policy will remain an ineffectual statement of intent. To ensure the effective implementation of mental health policies, the WHO recommends that all mental health policy be accompanied by an action plan; a document that clearly sets out the activities and strategies required to achieve the stated objectives of the policy, including clear timeframes, targets and indicators, and methods for monitoring and evaluating the implementation process (WHO, 2007).

Mental health policy should be complemented by mental health legislation; legal provisions that protect the human and civil rights of individuals with mental illness. While legislation in this context can, and should, address topics such as the legal rights of consumers, capacity issues and accreditation of mental health professionals, it can also function to promote community-based care and reduce long-term psychiatric admissions (WHO, 2008a). For example, in line with the principle of 'least restrictive treatment', legislation in many European countries stipulates that compulsory hospitalisation may only occur in instances where community-based treatment is not viable or has failed, and that the duration of admission must be no longer than necessary (see Freeman & Pathare, 2005). Legislation can also be leveraged to enable priority access to housing (e.g. Finland; Mental Health Act, No. 1116, 1990) or protect employment (e.g. UK; Disability Discrimination Act [DDA] 1995). It must be acknowledged, however, that such legislation can only function if the appropriate community services exist, again, highlighting the need for a co-ordinated and planned approach to deinstitutionalisation.

Appropriate resources

In Europe, national expenditure on mental health ranges from 0.12-1.02% of GDP; there are concerns that, in some countries, financial contributions, in the form of specified mental health budgets, may be insufficient to develop or maintain community services (Medeiros et al., 2008). Indeed, limited investment in mental health systems, whether due to competing priorities, austerity or poor economic growth, is implicated in the observable, and widening, treatment gap – the difference in the proportion of individuals who require treatment and those that receive treatment. As stated by Knapp and colleagues (2006) “...there are not enough resources available in the right places or at the right times, or allocated appropriately, to meet the mental health needs of populations” (p.158). A number of high quality studies have demonstrated that, due to the vast financial burden of mental illness, appropriate investment in community mental health systems can lead to long-term economic benefits (e.g. Chisholm et al., 2016).

Funding for community services, in the context of deinstitutionalisation, has typically been sourced from budgets that were previously allocated to hospital-based settings. Deinstitutionalisation should not be used to justify cost-cutting to mental health services; finances previously invested in hospitals should be protected (‘ring fenced’) and used for investment in new community services. In most situations, however, additional funds will be required to facilitate continuity of care during the transition (McDaid, 2005). The progression from hospital to community based services is a delicate process; striking the appropriate balance between hospital-based and community-based services is imperative, and the specific configuration of the resulting system will be highly dependent on the local social and economic contexts (e.g. low, lower-middle, upper-middle, and high income countries) (see Thornicroft, Deb & Henderson, 2016).

4.2. Barriers / key challenges

Lack of political will

Due to the complexities inherent in the design and co-ordination of community mental health services, a lack of political will, and/or active professional and public advocacy, can severely impede the proper implementation of these services. Broader societal issues, such as economic stagnation and unemployment, and other natural and human crises, have, too often, enabled some governments to avoid their stated political commitment to effective community mental health care; in these situations, the non-hospital based services that do exist have largely been implemented as a result of individuals and organisations, as opposed governments (Winkler et al., 2017). However, as stated by Saraceno and colleagues (2007), “Many of the barriers to progress in improvement of mental health services can be overcome by generation of political will” (p.1164).

Generating political will is a complex process, but will typically result from social pressures, direct advocacy and various economic, social and political incentives. Recent publications have sought to provide guidelines and tools to assist in rectifying a misalignment between political and public will in promoting positive social change (e.g. *‘Guide to Generating Political Will and Public Will’*; Raile, Raile & Post, 2017). Within contemporary governmental structures, the effective implementation and maintenance of community mental health services will require collaboration between ministries and

statutory services (including health, social care, housing etc), with a shared commitment to resolve the problem and uphold individual accountability.

Lack of investment in community mental health systems and a shift to non-statutory provision

A rigid focus on cost-cutting or efficiency can lead to reduced access to care and quality of services. By definition, components of a mental health system are interconnected, and the poor functioning of one component will lead to increased pressures on others. For example, under-resourced community teams can cause increased rates of bed occupancy in inpatient settings, longer duration of admissions and contribute to the ‘revolving-door’ phenomenon, whereby some individuals will require frequent readmissions to inpatient services; in the UK, the Commission on Acute Adult Psychiatric Care (Crisp, Smith & Nicholson, 2016) found that 30% of delayed discharges were associated with the absence of good-quality, well-resourced community teams. Highlighting the importance of the balanced care model, the inverse of this situation is also of concern; a lack of acute beds can lead to some individuals being maintained inappropriately in the community, thus putting increased pressure on community teams, impacting on the quality of care and safety of other service users in the community. In the UK, a country with one of the highest levels of investment in mental health services in Europe, a lack of local services for people with more complex mental health problems has led to increasing numbers being hospitalised in the independent sector many miles from home; the Care Quality Commission (CQC) has asserted “We do not consider that this model of care has a place in today’s mental health care system” (2017, p.8). It is essential that appropriate investment in local, community mental health services be maintained in order to preserve the quality of provision, safety of service users and morale and wellbeing of workforce.

In many European countries, public mental health services are supplemented by NGOs and third sector providers, typically offering accommodation, advocacy, employment and drug and alcohol services; indeed, these providers can improve the diversity and nature of mental health supports, improve access, and reinforce insufficient or ineffective public systems (Ala-Nikkola et al., 2016). Integration of these services into mental health systems is typically justified by financial efficiency – it is argued that a market-driven approach to health and social care should lead to improved provision at a reduced cost – however, an overreliance on these providers can contribute to re-institutionalisation (Priebe, 2004). Due to their unique position, third sector organisations may have financial incentives to expand the number and size of their services and retain service users longer than is necessary (particularly in residential settings), thus actively working against the principles of deinstitutionalisation. In addition, a reliance on unqualified or poorly trained staff (to reduce costs) and the provision of non-permanent employment contracts and poor remuneration, may lead to a transient workforce providing low-quality support and limited continuity of care.

5. Relevant activities in the EU and in the Member States

In 2005, the European Commission Green Paper on improving the mental health of the population highlighted the importance of promoting the social inclusion of those with mental health problems and the protection of their rights and dignity (EC, 2005). Since then the EC promoted a significant

number of initiatives addressing deinstitutionalisation, community mental health care and social inclusion of people with mental disorders.

The European Pact for Mental Health and Well-being launched in 2008 had "Combating Stigma and Social Exclusion" as one of its priorities. As a key element to implement the Pact, in November 2009 the Commission organised a thematic conference on "Promoting Social Inclusion and Combating Stigma for better Mental Health and Well-being". Two of the main objectives of the conference were, firstly, to encourage policy makers to support the transition towards community-based settings in mental health care and, secondly, to promote the coordination between health and social sectors in the delivery services for people with mental health problems.

In June 2011, the Council of Ministers invited Member States and the Commission to setting up of a Joint Action on Mental Health and Wellbeing, and proposed that it should look into, inter alia, in particular into "managing the evolution of community-based and socially-inclusive approaches to mental health".

One of the key EU Joint Action on Mental Health and Wellbeing reports is dedicated to the transition to community mental health care (Caldas de Almeida et al., 2015), and in it we can see a description of the European projects and initiatives that contributed to this objective by promoting research, strengthening networks, mapping of resources and practices, and developing recommendations and guidelines. Among these, the *DECLOC* project (*Deinstitutionalisation and Community Living – Outcomes and Costs*) in 2009, identified successful strategies for replacing institutions with community-based services, paying particular attention to economic issues in the transition process. The *MHEEN* (*Mental Health Economics European Network*) project (2005-07) estimated cost-effectiveness of mechanisms and strategies to assess mental health service utilisation and costs. The *Development of a European Measure of Best Practice for people with longer term mental health problems in institutional care (DEMOBinc)* project led to the development of a toolkit that assesses the living conditions, care and human rights of people with longer term mental health problems in psychiatric and social care institutions. The *ITHACA* (*Institutional Treatment, Human Rights and Care Assessment*) project developed a toolkit that provides information on monitoring practices, explain appropriate human rights literature and conventions and outline audit/monitoring procedures for an on-site visit. With a focus on the ways in which mental health care is financed, the *REFINEMENT* (*Research on Financing Systems' Effect on the Quality of Mental Health Care*) project led to the development of toolkits for mapping services, analyze data and information available from disparate and fragmented sources, and to aid decision-makers select health care financing arrangements. Practical advice is provided by the *Common European Guidelines on the Transition from Institutional to Community-based Care*. With a different perspective, the *European Network on Independent Living / European Coalition for Community Living Report* provided relevant information to assess the extent to which the EU has complied with its obligations set out under Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD).

The above-mentioned Joint Action Mental Health and Wellbeing report also includes an analysis of the activities developed by Member States contributing to the development of a more community-based mental health system. This analysis reveals that, in 2013, the integration of mental health in primary care, deinstitutionalisation, and development of community-based care were assumed by more than half of EU countries as major goals of their mental health policies. Most countries had promoted the availability of mental health care in primary care. Very significant advances were also made in the development of short-stay inpatient care in general hospitals. Although in a less

systematic and variable way, residential facilities in the community were developed in most EU countries, contributing to provide residential support and psychosocial rehabilitation in the community to people with severe mental disorders who have not the possibility to live independently. The number of outpatient facilities and outpatient visits had been increasing in most countries where information is available. Community mental health centres also increased in a significant way in most countries.

Information collected through the EU Compass survey show that further advances were made since 2015. According to Member states' representatives, the highest levels of implementation of specialist mental health services in the community took place in specialist outpatient clinics (77%), followed by community mental health teams (46%), 24 hours' crisis care (42%), and rehabilitation services and residential facilities (39%); while the lowest level was found in primary care liaison and early interventions. The higher proportion of patients with severe mental illness receives routine follow-up in outpatient clinics in community-based psychiatric units, and outpatient clinics in mental hospitals. Settings such as home treatment, assertive outreach teams and other are providing fewer proportion of follow-up community care to people with severe mental illness.

Regarding the level of implementation of recommendations to provide community-based mental health services in 2015-2017, the most implemented recommendations after 2015 were: ensuring that community psychosocial support is available for people with severe mental disorders; promoting the social inclusion of people with long-term mental disorders; ensuring quality of care improvement and the protection of human rights across all parts of the system; promoting the active involvement of users and carers in the delivery, planning and reorganisation of services; and developing self-help and users and carer groups.

The recommendations that were the least implemented were: improving the use and effectiveness of monitoring mechanisms of mental health services; stopping new admissions to psychiatric institutions, or 'closing the front door'; and integrating mental health in primary health care;

The majority of the countries (80%) reported activities related to reorganization of services. Many of these activities were focused on the creation/development of community services and deinstitutionalization, as well as in the development of psychological support in primary care. For example, a reform of mental health care for adults in Belgium included the increase of mental health professionals in the existing mobile teams and the creation of new mobile teams. Latvia approved an Action plan for deinstitutionalization and developed guidelines on community based social services and efficient management for people with mental disabilities. In Cyprus, a new legislation on community mental health care has been submitted for approval by the Parliament; its primary aim is the development of community residential health facilities for persons with mental health issues. The Czech Republic launched a mental health services reform with the support of EU structural funds, which focused in 2017 on building new centres of community mental health care and on a deinstitutionalization project including necessary changes in legislation, quality measures and also transformation of psychiatric hospitals. Greece also approved a mental health plan aiming at the reform of mental health care and initiated in 2017 a quality improvement project with the EU and WHO support. In Italy, the process to close down all Forensic Hospitals in the Country — one of the most innovative developments in the last few years in Europe — has been completed. In Lithuania, the network of day centres was expanded and crisis intervention centres were created. The current policy in the Netherlands is aimed at improving quality of care and decreasing costs by treating patients in outpatient/community based facilities or at home instead of intramural care; and the general practitioners that contracted a psychological assistant increased up to 80%. Norway also

invested in having psychologists in municipalities, and developed the project Mental Health Care Now, which is based on the British program on improving access to psychological interventions. The Swedish government has adopted a national strategy for mental health for the period 2016-2020. The strategy is based on five focus areas that have been identified as the main challenges when it comes to promoting mental health and wellbeing and combating mental ill health: preventive and promotional efforts; early access to services; vulnerable groups; participation and rights; and organization and leadership.

6. Recent innovative practices

In recent years, many innovative practices were developed in the EU, which have not yet been assessed as good practices⁴, but already represent promising advances in community mental health care. The following examples from EU Member States provide some examples of those innovative practices.

Greece

The Society of Social Psychiatry and Mental Health (SSPMH)

The SSPMH (<http://ekpse.gr/el>), a network of community mental health services, is a non-profit, non-governmental scientific organization founded in 1981 that offers training and provides care through community mental health centres. Training is organized for professionals and volunteers, both in mental health and in other sectors of the community. Mobile Psychiatric Units (MPU) have been set up to provide community mental health care in remote areas in Central and Northern Greece. The Society works in collaboration with the University of Thrace.

In 2015, an action platform to promote rights in Mental Health, which included advocacy and self-advocacy for people with mental health problems, was set up. In 2016, the Society started providing psychosocial support to refugees and promoting their inclusion into local communities in collaboration with Athens Municipality and other organizations.

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⁴ According to criteria developed in the context of the approach on Non-communicable- diseases in the Directorate General for Health and Food Safety in the European Commission.

Italy

The Verona experience

Following extensive and radical reforms, both in health and mental health care in 1978, all psychiatric hospitals have been closed and mental health services are exclusively based in the community; where psychiatric units for new admissions are based in general hospitals (Thornicroft & Tansella, 1999). More recently, in May 2014 new legislation was approved by the Italian parliament to close all six forensic psychiatric hospitals with a total of 1000 patients; marking perhaps another revolution in Italian mental health care (Barbui & Saraceno, 2015).

Not long after the 1978 mental health reform, the University of Verona, jointly with the Local Health Authority established the South Verona Community-based Mental Health Service (South Verona CMHS). The service has been intensively monitored and evaluated by the Section of Psychiatry of the University of Verona, using an epidemiological framework, and has become a World Health Organization collaborating centre for research and training in mental health (<http://www.psychiatry.univr.it/>). The Department has produced one of the most intensive evaluative efforts in the field of mental health (Ruggeri & Lozzino, 2016). These research efforts include, for example, the GET UP project, embedding early psychosis teams into existing community teams (Ruggeri et al, 2015), the VALERE project evaluating at the outcomes of those living in residential facilities and the PERSONE project to describe the socio-demographic and treatment characteristics of patients with an admission to a Forensic Hospital (Hopkin et al., in press)

Mirella Ruggieri and Chiara Samele

Romania

Two way integration in Suceava

NGO's play an important role in the development of mental health care in Romania and the Romanian League for Mental Health (founded in 1990) was the first organization involved in mental health promotion (www.lrsm.org.ro). An initiative in Suceava in the north provides an example of an innovative practice. The community mental health service was set up as an initiative of the local residential institution with the purpose of achieving a better understanding of the needs of the patient with mental health problems and in pursuing their best interests. The doors of the Siret Psychiatric Hospital (www.lrsm.org.ro) were opened allowing patients to go and participate in the community activities.

Since then a comprehensive program to support users in the community was developed. This program offers, aside from medical treatment, complex evaluation services, occupational therapy, educational activities for independent living and relaxation activities. It should be noted that, after the opening of the hospital doors, people from the local community were interested in coming to the hospital and in supporting its activities. Thus a reverse integration process took place as well. Through this work it was possible to develop an important volunteer network that provides relaxation activities in the community together with the beneficiaries of the institution.

Tiberiu Rotaru and Raluca Nica

Portugal

Integrated care

The Hospital Centre of Western Lisbon Department of Mental Health, responsible for mental health care in this area of Lisbon (300.000 inhabitants), included since the 90's a psychiatric service in a general hospital (with inpatient, day care, child/adolescent and C/L Units) and 5 Community Mental Health Teams each providing outpatient mental health care to a catchment area of around 100.000 inhabitants, in collaboration with primary health care services and psychosocial rehabilitations facilities ran by a NGO. In 2013 the Department initiated a project that aimed to assess the feasibility and impact of an integrated care program for people with severe mental disorders, based on a clinical case management model. Since then, all patients with a severe mental disorder are allocated to a case manager, responsible for the coordination of an individual care plan, including psycho-education and family-based interventions, strategies for dealing with the clinical aspects, relapse prevention and interventions to improve social and occupational functioning. These interventions are associated with psychopharmacological treatment.

Two assessments with an interval of one year were made and the following dimensions were evaluated: implementation of the programme, psychopathology (BPRS), needs (CAN), disability (DAS), social and occupational functioning (SOFAS), attitude toward medication (DAI), insight (SAI), quality of life (WHOQOL-S) and satisfaction (POCS).

An individual care plan was developed for 98% of patients, with family participation in 38.9% of the cases. On the first assessment, 42 patients (28.7%) were attending psychosocial rehabilitation facilities and 12 months later that number had increased to 80 (73.3%). In the same period the number of patients in full time employment rose from 8 (7.4%) to 18 (16.7%).

The results showed a statistically significant impact of the programme at the level of psychopathology, needs, disability, social and occupational functioning, quality of life and patient satisfaction. In the year after the beginning of the programme, the number of admissions, days of hospitalization, and number of relapses decreased respectively 64.1%, 65.6% and 45.6%. This programme was especially relevant in Portugal because it showed that it is possible to implement, with good results, a clinical case management model with the human and material resources usually available in the community mental health teams that exist in the country.

Luis Sardinha and Joaquim Gago

Sweden

The Resource Group ACT Kit

During 1994-2002 a small Reach-Out community mental health team in Gothenburg participated in a large international project focused on studying the effects of the “Integrated Care” (IC) program.

One element of IC was to establish a care unit in the community around the family of the patient. Family members assured us that getting support from and being a part of such a unit improved their quality of life. Patients genuinely praised us for placing them at the helm of their own team on their recovery voyage. Case managers and psychiatrists appreciated their experiences of rewarding working alliances. First recognized as something like an extended family intervention this clinical practice was developed into a stand-alone concept, viz. a resource group (Malm et al, 2015). The context was one of national and international collaboration mediated by the front man of IC, Ian Falloon. A new mechanism for successful service delivery for person-centred treatment and care of persons with severe mental illness had been identified. The major outcomes of the research project were significantly improved social function and satisfaction with services of the IC patient group in comparison with best practice (Malm et al, 2003; Malm et al, 2014).

Some years later a qualitative study confirmed the key role of resource groups in the recovery process (Norden et al, 2012) and the Resource group ACT kit was born in the Västra Götaland County of Sweden.

Ulf Malm

7. Conclusions

Over the past decades a great deal of effort has gone into reforming mental health systems and services and to ensure high-quality community-based care for people with mental disorders in the EU. Deinstitutionalization and development of community-based care have been adopted as major mental health policy goals for more than half of EU countries. Long-stay psychiatric hospitals have been losing their central role in mental health systems, although many countries continue to have a predominance of these hospitals, which consume the majority of resources allocated to mental health.

Overall, mental health services reforms have helped to advance and vastly improve mental health care in many EU countries. Improvements have been made to the living conditions in long-stay psychiatric hospitals, the development of community services, the integration of mental health care within primary care, the development of psychosocial care, the protection of the human rights of people with mental disorders and the increasing participation of users and families in the improvement of policies and services.

However, despite these advances, community-based services networks have only partially been developed in most countries, with many not introducing timely transfers from traditional services to community based systems of mental health care.

The highest level of the development has been seen in the inclusion of inpatient psychiatric units in general hospitals, followed by the development of outpatient services in general hospitals and in the community, day care services and community mental health centres. By contrast, the less developed services include primary mental health care, followed by the development of home treatment, community-based rehabilitation, outreach or mobile mental health teams, e-health and self-help and other users groups.

The largest barriers to transferring to community based care include low political priority, and insufficient and inadequate funding. This is followed by the lack of consensus among stakeholders and cooperation between health and social sectors, difficulties with integrating mental health into primary health care, the lack of clear or strong leadership, and resistance to change. Facilitating factors include strong government support, good leadership and governance, and participation of users and families and NGOs.

8. Principles and recommendations

8.1. Principles

1. Protection of human rights
2. Accessibility and equity
3. Recovery
4. Care in the community
5. Coordination and integration of care
6. Community participation of users and families

8.2. Recommendations to Member States and relevant stakeholders

1. Develop advocacy strategies to generate political commitment, based on information that can demonstrate to policy makers why they should make a commitment for action;
2. Promote debate and build consensus on the incorporation of CRPD principles in mental health legislation;
3. Develop/update mental health policy aiming at moving away from institutional care to integrated and well co-ordinated community based mental health care, including inpatient treatment in general hospitals;
4. Develop efficient mechanisms for funding mental health care that are commensurate to the needs of the population; including incentives that promote the development of community-based care;
5. Promote actions that ensure the efficient use of available resources and those to be reallocated from long-stay psychiatric hospitals to community-based services;
6. Improve leadership and governance of the mental health system at all levels;
7. Integrate mental health in primary health care and scale up collaborative care;
8. Promote the active involvement of users and carers in the delivery, planning and reorganization of services;
9. Monitor and substantially improve the quality of care and respect of human rights for people who continue to reside in long-stay psychiatric hospitals; abolishing any practices that involve physical restraints;
10. Develop a concerted effort to reduce and ultimately cease admissions to long-stay psychiatric hospitals;
11. Create/strengthen integrated and comprehensive community-based services for each catchment area, according to local and national needs;
12. Develop facilities and programmes that have so far been underdeveloped in many EU countries, such as integrated programmes with case management, community rehabilitation services for complex cases, outreach or mobile mental health teams, E-Health, self-help and users and carer groups;
13. Develop structured cooperation between mental health services, social services and employment services, to ensure that community-based residential facilities, vocational programmes, and other psychosocial rehabilitation interventions are available;
14. Promote the use of the opportunities provided by the EU 2020 Strategy on research and development to improve the monitoring and evaluation of policies addressing the social exclusion of people suffering from mental disorders.

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