European Community based Mental Health Service providers (EUCOMS) Network

EUROPEAN PARTNERSHIP FOR DELIVERING QUALITY COMMUNITY MENTAL HEALTH SERVICES

RECOVERY FOR ALL IN THE COMMUNITY

LEARNING FROM EACHOTHER

Consensus Paper on Fundamental Principles and Key Elements of Community Based Mental Health Care

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Introduction

Community mental health is a holistic response and approach to mental ill-health, leveraging community resources to ensure that persons with mental ill health can exercise their right to receive care and supports in their own environment, and optimise the possibility for recovery.

Community mental health as we know it today has started after World War II as a response to the closing of mental hospitals and transitioning of care to the community. Two phases have been described. The first, 1950's-1970's. consisted of small local improvements that came together in relatively simple multidisciplinary teams, a slow evolution rather than a revolution (Burns & Firn, 2017).

The second phase started in 1980 with the landmark publication on assertive community treatment (Stein & Test, 1980). Community mental health services had more emphasis on the support of the human right of participation in the community and organised a richer multidisciplinary and multisector approach, combining population level approaches for prevention and promotion of health. Community mental health requires a clear commitment to the recovery philosophy, promotes the use of evidence and context based interventions and uses various resources and contacts in the broader community network. As a consequence of the recovery philosophy, the person with mental ill health became a partner in creating the mental health services.
The Importance of Community-Based Mental Health Services

Mental ill health poses a substantial burden on society; to illustrate, depression alone affects 30.3 million people in Europe, and psychosis affects 5 million people (Wittchen et al., 2011). Several decades of research have shown that mental disorders are treatable, yet continue to impose disability to a substantial number of people, many of whom reside in low and middle-income countries (LMICs) or who are in compromising health and/or socioeconomic situations in high-income countries (Meffert, Neylan, Chambers, & Verdeili, 2016). There is substantial evidence on what effective care consists of for people with mental ill health. Despite this knowledge and available evidence, many citizens still do not have access to optimal mental health care (Caldas Almeida et al., 2016; Manfred Huber et al., 2008). The aim of community mental health care is that citizens can enjoy good health and wellbeing.

People with (serious) mental health problems experience social disadvantages and unmet needs in multiple life domains. They need access to high quality treatment in their community to enable them to go through life as citizens with equal value. Compared with mental health services primarily provided in hospital-based settings, integrated networks of good quality mental health services embedded in the community are associated with better client outcomes (higher quality of life, better treatment adherence, less stigma, more housing stability, better vocational rehabilitation) and service outcomes (improved access to care, less coercive measures, fewer human rights violations) (World Health Assembly, 2013).

In most circumstances concerning mental ill-health, a comprehensive, community-based approach can help people with mild, moderate and severe mental health problems in their recovery and in improving their quality of life. Here, community mental health refers to a combination of self-care and self-management, help by the informal network of family and close ones, support by generic community resources and services (employment, housing, recreation, health) and therapy and support by mental health professionals (Trainor & Church, 1984).

Despite the benefits of community-based care, mental health care in many European countries is still provided in hospital-based settings. In some countries, community mental health services are only partially implemented, due to insufficient political commitment or resources (both human and financial). Given the great variety in care practices and organisation of services in different health
systems throughout Europe, a clear set of criteria that supports the implementation of effective community-based services for people with mental health problems across different contexts is needed.

This consensus document describes the fundamental principles and key elements of community-based mental health care. The consensus is based on the expertise of service providers throughout Europe who have identified the shared problem of needing to define to governments, commissioners and funders what good community mental health care looks like. The dimensions of community mental health care and criteria to fulfil these dimensions are based on a synthesis of scientific evidence, good practices and expert opinions that were discussed in a network of professionals, users and their close ones, with extensive expertise and experience in the fields of community mental health care in Scandinavia, the British Isles, Western, Southern, Central and Eastern Europe.

The aim of this consensus document is to serve as a foundation for regionally-organised models of community mental health in Europe and beyond. The document is intended for persons who practice, organise and use mental health services. It can help services that (plan to) start with the implementation of community mental health as well as existing services to improve functioning. One of the foundations that have inspired the principles in this document is the Oxford Textbook of Community Health (Thornicroft et al, 2011).
Structure of Consensus Document

In this consensus document, we conceptualise health not as a static condition but as the dynamic ability to adapt and self-manage one's own well-being helping to address the physical, emotional and social challenges of life (Machteld Huber et al., 2011; Thornicroft, Szmukler, Mueser, & Drake, 2011). The emphasis thereby shifts from ill-health to resilience and well-being and helps all stakeholders to change their thinking about health care and disease prevention.

The consensus document describes what good community mental health care looks like from six different perspectives, each constituting an important dimension for good community mental health:

- Ethics
- Public Health
- Recovery
- Effectiveness of interventions
- Community network of care
- Peer expertise

Each perspective is introduced by an image that illustrates the principle of this perspective, followed by the conclusions and recommendations. In the final chapter, we summarize these perspectives and conclude what we have achieved regarding these six perspectives.
1. The Ethics Perspective

Figure 1. Book cover: Asylums (Goffman). This book published in 1961, underpins that deinstitutionalization is driven by human rights and shows this has been on the agenda for decades already.
CONCLUSIONS AND RECOMMENDATIONS ON THE ETHICS PERSPECTIVE

- The focus on human rights is a fundamental principle in community mental health care: the right of access to needs based care in the least restrictive environment and the right of full participation in community life. This includes civil rights, citizenship and cultural, spiritual, sexual and political freedom.

- Ensuring the right to mental health care in legal and policy documents is an essential strategy for enshrining the rights of persons with mental ill health in practice.

- We recommend that mental health services base their mission and vision on the United Nations’ Convention of the Rights of Persons with Disabilities (CRPD, 2008) that sets out the right to live, participate in the community, education, health, employment, housing and social protection.

- Providing training and coaching for staff of community based and inpatient mental health care settings on recovery and rights is a helpful step to reducing human rights violations that occur in the context of mental health services.

- The Quality Rights Toolkit of the WHO offers a training framework for assessing and improving quality of mental health services.
The ethics perspective has been on the agenda for decades as one of the 3 E’s: ethics, evidence and experience (Tansella & Thornicroft, 2009). The visible start of this was the landmark publication of Goffman’s Asylums in 1961, with 4 controversial essays that raised the question whether psychiatric institutions are genuine havens of rest from the pressures of society or are organizations that create even more crippling tensions in those who are already disturbed. (Goffman, 1961) There were more authors in the same vein. In the 1960’s and 70’s the Italian psychiatrist Basaglia concluded that many stereotypes of madness were actually the consequence of institutional treatment and advocated the liberation of patients and the destruction of the mental hospital as a place of institutionalisation (Foot, 2014). Harding described chronic conditions like schizophrenia as artefacts based upon fear (Harding et al., 1987).

The process of deinstitutionalisation therefore is underpinned by the ethics perspective, that mental health services exist to protect and not to violate human rights (The European expert group on Transition from Institutional to Community-based Care, 2012).

The use of coercion in mental health care is both common and controversial, and involves many complex ethical challenges. On the one hand coercion is seen as a necessary tool to protect individuals and society against harm. On the other hand, there is very little scientific evidence available that coercion has positive effects. Negative effects are known: coercion results in avoiding help seeking (Molodynski, Rugkasa, & Burns, 2010) and coercive admissions can be experienced as traumatic (Paksarian et al., 2014). However, there are also indications for understanding of some patients on the necessity of coercion (Newton-Howes & Mullen, 2011).

The ethical dilemma is in the tension between the right to treatment (right to mental health care taking into account the unmet need and the disabilities of people with psychological problems) and the right to reject/refuse treatment.

Positive promotion of mental health and human rights is mutually reinforcing, as together they substantially advance the overall well-being of the population (Gostin & Mok, 2009; Pathare & Sagade, 2013). Despite this notion, violations of civil, cultural, economic, political, and social rights continue to exist for people with mental ill-health (Drew et al., 2011).
Ensuring the right to mental health care in legal and policy documents is an essential strategy for enshrining the rights of persons with mental ill health in practice. In some countries across Europe, care is still primarily provided within inpatient or hospital-based settings. If care in the community is available it is often of poor quality. Both situations fuel exclusion from community life which negatively impacts the ability to integrate in society, achieve recovery goals, and lead a meaningful life. In 2008, the Convention of the Rights of Persons with Disabilities (CRPD) came into force and created an impetus for change in disability and mental health laws worldwide (UN General Assembly, 2007). The CRPD sets out the right for persons with disabilities (including people with mental health issues) to live and participate in the community, as well as ensuring the right to education, health, employment, housing and social protection.

The CRPD marks a ‘paradigm shift’ in attitudes and approaches to persons with disabilities, including mental ill health. Persons with disabilities are not viewed as "objects" of charity, medical treatment and social protection, rather than as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society. For the CRPD disability is an evolving concept, and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others.

In terms of the CRPD participation is important to correctly identify specific needs, and to empower the individual. Full and effective participation and inclusion in society is recognized in the CRPD as a general principle, a general obligation and a right.

Promoting the availability of quality services available close to people’s homes that integrate respect for human rights is also a priority area for action in the World Health Organization’s Comprehensive Mental Health Action Plan 2013-2020 (World Health Assembly, 2013). The UN Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2017) recommends:

‘a paradigm shift [is needed] that is recovery and community-based, promotes social inclusion and offers a range of rights-based treatments and psychosocial support at primary and specialized care
levels (...) reductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health'.

**Rights in the Convention**

- Equality before the law without discrimination (article 5)
- Right to life, liberty and security of the person (articles 10 & 14)
- Equal recognition before the law and legal capacity (article 12)
- Freedom from torture (article 15)
- Freedom from exploitation, violence and abuse (article 16)
- Right to respect physical and mental integrity (article 17)
- Freedom of movement and nationality (article 18)
- Right to live in the community (article 19)
- Freedom of expression and opinion (article 21)
- Respect for privacy (article 22)
- Respect for home and the family (article 23)
- Right to education (article 24)
- Right to health (article 25)
- Right to work (article 27)
- Right to adequate standard of living (article 28)
- Right to participate in political and public life (article 29)
- Right to participation in cultural life (article 30)

**Text box 1. Convention on the Rights of Persons with Disabilities**

Enshrining rights in practice can take multiple forms. One way is through legal reforms, an important strategy to ensure that the rights of all people are respected on the same legal basis. Other strategies at the services level include training for all staff working in wards as well as in community-based mental health services on how to respect the rights of people with mental ill-health in practice. This means carrying out training on elements that include (but are not limited to): when to use coercion and restraint, autonomy of the person with mental ill-health to make important decisions about their treatment and care and creating a therapeutic environment which is least restrictive. The World Health Organization’s Quality Rights Toolkit is one example of a training framework for assessing and improving quality of mental health services, including community-based services, and can guide service providers and/or national stakeholders on the
steps to achieving good quality services which enshrine human rights (World Health Organisation, 2012).
2. The Public Health Perspective

Figure 2. Social life takes place in communities that bind people into relationships with one another. In community mental health the relevant community is the people who live in a defined geographic locality, the catchment area. The mission of a community mental health service is supporting the health of all citizens in that area.
CONCLUSIONS AND RECOMMENDATIONS ON THE PUBLIC HEALTH PERSPECTIVE

- Community mental health services work for the health of all citizens in their catchment area. This includes existing clients, clients who need care but are hard to engage and potential future clients.

- Addressing mental ill-health in the community means not only treatment and care but also prevention and promotion of good mental health. Taking actions to eliminate discrimination and reduce stigma are essential.

- Community mental health care works with multidisciplinary teams in well-defined regions. The size of the region depends on the regional demography, prevalence of mental ill health and the resources of mental health care. It is a trade-off between the advantages of a small region (ability to be present, collaboration with a small number of family doctors) and the necessity of sufficient resources to form a multidisciplinary team.

- Concepts of community mental health care were developed for the treatment of persons with severe and persistent mental ill health, yet apply to all mental health needs (and beyond).

- Mental health is a public health issue (relevant to high numbers of citizens in the population). It requires of mental health services to provide a recovery oriented approach and presence in the community.

- Care for persons who are hard to engage is a core task of community mental health teams.
Public health is the art and science of protecting and improving population health. These populations can be as small as a local neighbourhood, or as big as an entire country or region. The central aim of the public health perspective is to achieve healthy individual communities, societies and environments, as well equity between different groups (Baum, 2015). For mental health, this implies that society and services must have a focus on the needs of the entire population regardless what proportion of the services are given by public services or by private organisations. A community mental health service works in a specific catchment area and therefore needs to account for the influence of specific cultural circumstances.

The importance of adopting a public health lens when developing and implementing good community mental health services lies in the focus not only on treatment (curative care), but on mental health promotion and prevention as well. This means taking the needs of the entire population into account, not only those with an existing mental health problem.

Taking into account population-level needs in practice translates to well-defined plans for mapping services and supports for different segments of the population. This helps to, for instance, define the geographical areas that a community mental health team can work in. The size of the region depends on the regional demography, prevalence of mental ill health and the available resources for (mental) health care. The demography determines the prevalence and needs of the population in that area, e.g. rural or urban area, socio-economic status, employment, the presence of immigrants or refugees. These characteristics have impact on the composition and specialities of members of a community mental health team.

The size of the region is determined by two conflicting principles. First the region must be small for the team(s) to be integrated in the local community and have a strong relationship with primary care and social stakeholders. On the other hand, the region must be large enough to mobilize resources to build a multidisciplinary team in that region. Therefore, the size of the catchment area is a trade-off between the advantages of a small region (presence, collaboration with a small number of family doctors) and the necessity of sufficient resources to form a multidisciplinary team. Within Europe the size of a catchment area can vary between 20.000 and 200.000 inhabitants per team.
Within a defined area, relevant actors across sectors should come together to respond to the mental health needs of that defined catchment area. Actors include to primary care professionals, mental health workers, social services, community centres, police, employers and local businesses.

Community mental health teams have an important task as treatment providers for persons with severe and persistent mental ill health, as well as consultants for other service providers (e.g. primary care providers) in the prevention of mental health problems and treatment of persons with mild to moderate mental ill health.

These teams also carry a responsibility for citizens in their region who are hard to engage and in need of care. Lack of motivation for treatment makes a subgroup of patients with severe mental illness difficult to engage in treatment, while they have been shown to be most in need of treatment. This ‘motivation paradox’ has clinical relevance, as it provides an ethical basis for outreach services which aim to engage marginally motivated patients with severe psychosocial problems into mental health care (Mulder, Jochems, & Kortrijk, 2014).

### 2.1. Assessment of Needs and Planning of Community Mental Health Care

Before a comprehensive network of community-based mental health services can be implemented, a thorough needs assessment should take place to understand the kinds of care and support that service users and their carers need.

The starting point for a community mental health service network is an assessment of the region’s characteristics that are relevant for mental health, involving at least the following:

- Information on size and characteristics of the population;
- Description of types and amounts of the existing services;
- Current plans and goals for existing community mental health services;
  - involvement of stakeholders (including service users and carers);
  - information on the type and amount of services that should be available, and of required multidisciplinary staffing;
- Defined quality standards for services, procedures for monitoring the outcomes, and plans for how and when the service network will be evaluated and revised.
National or regional plans or standards add value to a service when they are adjusted to the local context. National and regional plans for health services must include and emphasize priorities and plans for community mental health care (Thornicroft et al, 2011; Thornicroft & Tansella, 1999).

2.2. Social Inclusion and Stigma Reduction

As previously mentioned, taking a public health approach to mental health means developing and implementing services and approaches which promote, prevent and treat mental health problems. Mental health promotion has, throughout the past few decades, taken on the form of social inclusion and anti-stigma campaigns, particularly in light of the paradigm shift of moving away from segregation of people with mental health problems towards one of promoting inclusion (Evans-Lacko et al., 2014). We define social inclusion as improved rights to access social and economic opportunities, ability to achieve recovery goals and to live a meaningful life in spite of disability.

A significant barrier to full community participation is the discrimination that people with mental health problems face (Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Discrimination against people with mental health problems is universally experienced and influences many aspects of people’s lives. Not only does it negatively impact on social integration but it also impacts help-seeking behaviour, as it produces changes in feelings and attitudes for both patients (lower self-esteem, poorer self-care and more social withdrawal) and their family members (feelings of guilt, shame, despair).

The employment rate among people with mental health problems is lower than in the general population due to the discrimination that people with mental health problems face in securing and maintaining employment (Brouwers et al., 2016). Additionally, experience of mental health problems early in life can be associated with a trajectory of exclusion (e.g. through reduced participation in higher education and increased risk of contact with criminal justice systems, victimization and homelessness). These patterns of stigma and exclusion can have significant consequences for people with mental health problems and may directly or indirectly lead to lower participation in healthcare, higher rates of mortality, higher levels of self-stigma and lower levels of empowerment. Close personal relationships and informal social support networks play a significant
role in buffering anticipated discrimination in people with mental health problems (Zoppei et al., 2014).

Stigmatising attitudes are not uncommon among mental health professionals who may be less than optimistic about outcomes for people with long-term mental health problems. These perceptions are probably related to the professional’s experiences, such as those working in the public sector dealing with clients with the most mental health-related problems (Horsfall, Cleary, & Hunt, 2010). Community mental health does not automatically take away stigmatization. This must be addressed in local targeted campaigns (Stuart, Florez, & Sartorius, 2012).

Policymakers, advocates and mental health professionals should make the elimination of discrimination and reduction of stigma a public health priority. It should be noted that discrimination and stigma are separate concepts, and require different strategies. Stigma, which the mental health arena has traditionally focused on, represents attitudinal aspects, whereas discrimination represents behavioural aspects (Bhugra, Ventriglio, & Pathare, 2016).

Although several anti-stigma and awareness campaigns in Europe have had demonstrable impact (Time to Change campaign in England, One of Us campaign in Denmark, and SeeMe campaign in Scotland), social distance and perceived danger associated with people with mental health problems is still present in many societies. Currently, well-known anti-stigma strategies are education (challenging myths with facts about mental health conditions) and contact (planned exchanges between people with lived experience and the general public) Results showed that contact programmes are more effective than education. Anti-stigma programmes should be based on the TLC3 formula: Targeted, Local, Contact, Credible and Continuous (Corrigan, 2011). Reconfiguring stigma reduction strategies requires providers and advocates to prioritize inclusion, integration and the development of competences among the general population to reduce cultural barriers to the recognition, response and recovery of people with a mental illness. Unless stigma is tackled at the cultural level, the prospects for changing the lives of those affected by mental disorders will be unlikely to happen.
Five principles for developing anti-stigma campaigns for mental health (TLC3 formula)  
(Corrigan, 2011)

- Contact: Organizing contact between people with and without mental illness is the key issue
- Targeted: Contacts must be targeted at critical groups in the community (e.g. employers!)
- Local: Local contact programs are more effective
- Credibility: Contacts must have credibility (clients in the lead)
- Continuous: Contacts must be continuous

Key ingredients contact-based anti-stigma programmes  
(Corrigan et al., 2014)

- Design: face-to-face presentations and audience discussion; include multiple contact mediums (e.g. live, video)
- Targets: specific group identified and assessment completed to derive stigma change goals (e.g. employers)
- Staff: presenters are people with lived experience; choose enthusiastic facilitator who can ‘set the tone’
- Messages:
  - Include on-the-way-up story (a person with lived experience tells his recovery story;
  - Emphasize and demonstrate recovery;
  - Teach ‘what to do’/give practical skills;
  - Dispel myths
- Evaluation/Follow-up: post presentation follow-up actions discussed with targets.

**Text box 2. Principles and Key Ingredients for Anti Stigma Programs**
3. The Recovery Perspective

Figure 3. Recovery is the journey of the client, a unique and individual process. The professional can be seen as a companion on this journey for as short a time as possible but as long as is necessary.
CONCLUSIONS AND RECOMMENDATIONS ON THE RECOVERY PERSPECTIVE

- Recovery is the client’s journey, and the task of mental health professional is to support and not to hinder this journey.
- People can and do recover even from the most serious mental health problems.
- Community mental health teams focus on recovery of health, social functioning and personal identity.
- We describe 10 ways to support recovery. The most important one is offering hope.
- Recovery-oriented care entails focusing on strengths of the service user and leveraging the existing resources around the client, however big or small those resources may be.
Recovery is defined by the person himself or herself, and is often defined by service users as a unique, individual process or experience, which can best be described as a journey. Recovery is focused on what you can do, not what you are unable to do. There are different dimensions of recovery. Clinical recovery is recovery from psychiatric symptoms, and functional recovery can be expressed as participation in society, in meaningful work and education. The final dimension, covered most in this chapter, is personal recovery, which constitutes recovery of identity and of self. Professionals in a community mental health service can be seen as companions on this journey for as short a time as possible but as long as necessary (Shepherd, Boardman, & Slade, 2008).

The most widely used definition describes recovery 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 within the 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” (Anthony, 1993).

The WHO mental health action plan defines recovery from the perspective of the individual with mental illness: gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self (World Health Assembly, 2013).

Recovery must be self-defined and self-directed by the ideographic and personalized narrative of each individual living the experience. From this perspective, because recovery assumes a sufficient level of ‘interpretative agency’ or autonomy which may have been eroded by an overly prescriptive or paternalistic psychiatric system, this agency may first have to be discovered.

Though the concept of recovery is increasingly applied in mental health services and in literature (Mike Slade, Williams, Bird, Leamy, & Le Boutillier, 2012), the degree to which it is defined as a user led service is variable. It needs to be emphasized, therefore, that simply re-branding a service as ‘recovery-oriented’ or haphazardly incorporating the word recovery in a logo or mission statement does not necessarily mean practicing recovery-oriented care. If recovery is generically defined by mental health professionals according to reductionist biomedical models of illness, it misses the point. The main paradigm shift is from the illness to the person as a whole.
Historically, mental health services have tended to emphasise compliance and management of problems and needs, with formal services which tended to be controlled by the professional. This deficit and/or problem-focused approach centres around the diagnosis as the core problem; questions are perused in relation to problems, needs, deficits and symptomatology. However, over the past few years, there has been a shift among service providers in Europe to move towards the realization of individual needs and personal goals from the user perspective, with emphasis on autonomy and decision-making power of the client, shared decision making and setting recovery goals.

This can be seen as a paradigm shift, moving towards a strength-based approach, which emphasises the strengths and resources of the person rather than his/her weaknesses. This transforms the whole notion of care; from suppressing symptoms and solving problems to a more holistic focus on recovery goals of the service user. It focuses care on what the person wants, desires, aspires to, and dreams of, linking that to the person’s knowledge, skills and resources. The strengths approach explores the rejuvenation and creation of natural helping and supportive networks as part of the solution. This approach is specific, detailed and individualised.

Strengths include resilience, survival skills, abilities, knowledge, resources and desires that can be used to help meet service user goals. From the initial contact, through goal identification, assessment and intervention to evaluation, the helping process is based on the underlying assumption that people have the capacity for growth, change and recovery. Slade and colleagues have specified ways for professionals to support the recovery of people with mental health problems (Mike Slade, 2009). We have defined 10 principles that can help the professional to serve as a guide on the journey to recovery. They sum up what professionals in mental health services can do to support and not to hinder the process of recovery.
1. Support recovery of health, functioning and identity
These can be regarded as the three domains of recovery. They are related, yet can be distinguished. There is no hierarchy. A recovery oriented treatment involves these three domains and is working with the clients on the domains where the client wants to succeed.

2. Offer hope for recovery
Offering hope is the key intervention. Without hope, a client will not start the recovery journey.

3. Ask ourselves in everything we do: do we help or do we hinder
Any intervention we do can potentially be counterproductive, as it may not match with the stage of recovery a person is in.

4. Focus on what’s strong, not on what’s wrong
It is important to explore the strengths, talents, ambitions and resources.

5. Decide with not about the service user
The professional and client make the decisions together. This process starts with the diagnosis that can be described as understanding together what is going on.

6. Acknowledge that the expertise of the service user is as important as our own expertise
A dialogue with a client is a meeting of two experts. The expertise of the professional consists of knowledge, experience and ability to have a dialogue. The expertise of the client is the experience, the goals and knowing what helped in the past and who or what are the resources.

7. Collaborate with our stakeholders
The larger part of recovery occurs outside of mental health services: at work, at school, with family, in the community. Therefore, community mental health services collaborate with social stakeholders.

8. Acknowledge the service user’s right to take risks
Denying the right to take risks undermines the possibility of recovery. The client advocacy movement emphasises ‘the dignity of risk’.

9. Collaborate with the family and network as a resource and partner
It is in most cases better to make the recovery journey together with others, family, partner, friends etc. This is the foundation for several approaches like the Resource group in Sweden (Norden, Malm & Norlander, 2012) and Open Dialogue in Finland and the UK (Razzaque & Wood, 2015) (Seikkula & Olson, 2003b)

10. Share and integrate knowledge
A recovery oriented treatment requires the integration of objective, subjective and normative knowledge.

Text box 3. 10 Ways to be a Good Guide in the Recovery of a Client
4. The Effectiveness Perspective

Figure 4. Evidence based medicine and the recovery attitude go together like oil and vinegar: two approaches that can be combined very well and together make a tasty vinaigrette.
CONCLUSIONS AND RECOMMENDATIONS ON THE EFFECTIVENESS PERSPECTIVE

- Effective interventions are an important tool of community mental health services to support recovery of their clients
- The task of community mental health services is to provide evidence informed context based mental health care
- Effectiveness of interventions is defined in addition to scientific evidence by: being well defined, reflecting client goals, durable outcomes, reasonable costs, adaptability to diverse communities and feasibility of implementation.
- Evidence based medicine and the recovery attitude are not of different camps and can be compared to oil and vinegar: two approaches that can be combined very well and together make a tasty vinaigrette.
- Recommended interventions reducing symptoms are psychopharmacology, cognitive behavioural therapy and motivational interviewing.
- Good community mental health care involves somatic screening and support of smoking cessation
- People increasingly participate in e-communities. Therefore, we recommend that community mental health collaborate with their clients using digital interventions with e-health and m-(mobile) health tools.
- Recommended interventions to improve social functioning individual placement and support (IPS) and Housing first. In general, the social inclusion is best supported by a first place then train approach and learning in practice.
Historically, the development of the mental health field can be viewed in three waves, or three eras (Berwick, 2016). The first era was concerned with professional dominance and self-regulation. Era two, the current era, is the period for evidence based medicine, accountability and market theory. The strength of this approach lies in that it has re-directed focus to evidence of treatment approaches and outcomes and steered away from the assumption that only doctors know the best course of action. The risk of such a strong focus on evidence-based medicine is that it reduces care only to what is proven and discards interventions or therapeutic approaches which may not yet be evaluated or sufficiently evaluated in effectiveness research designs. Evidence-based medicine can also to a certain extent ignore the value of knowledge from the individual (client perspective) and environmental (local support network) in care. The third and upcoming era in mental health is the moral era, with a reduction of mandatory measurements, giving up the professional prerogative, and a transition to civility and collaboration with patients and carers (Berwick, 2016).

Good community mental health care uses a package of interventions that are evidence-based, i.e. with high-quality scientific evidence to support effectiveness or substantial benefit over harm. Single effective interventions are embedded in the overall services context and related pathways of care. In many countries, such interventions are detailed in national or regional clinical guidelines. A strong working alliance is a prerequisite for collaboration in a community mental health service as it is a cornerstone for positive treatment outcome (Melau et al., 2015).

Community mental health requires a combination of pharmacological, psychological, somatic and social interventions that complement each other in promoting health and reducing symptoms. This could include a combination of medication with cognitive behaviour therapy, or medication with supported employment (through Individual Placement and Support interventions). As community mental health is provided in one’s own natural environment, context-driven information is essential for improvement of health, which may require adaptation of intervention to reflect local realities and resources.

Good community mental health care provides support to citizens of all ages, with a continuum between the services for the different age groups. For child and adolescents, it is important to meet the broader transitional care needs of 'emerging adults' and their mental health needs. We support the transition psychiatry approach: developing robust transitional mental health care by addressing
the policy-practice gap and development of accessible, acceptable, responsive, age-appropriate provision (Paul, Street, Wheeler, & Singh, 2014).

For the elderly, we see that mental ill health often is part of frailty, a common and important geriatric syndrome characterized by age-associated declines in physiologic reserve and function across multiorgan systems. We need to develop more efficient methods to detect frailty and measure its severity in routine clinical practice. Such progress would greatly inform the appropriate selection of elderly people for invasive procedures or drug treatments and would be the basis for a shift in the care of frail elderly people towards more appropriate goal-directed care (Clegg, Young, Iliffe, Rikkert, & Rockwood, 2013). Community Mental Health services are an important contribution to reach the WHO goals for the decade of Healthy Ageing, with a shift from disease and disorder to capacity and ability (Beard et al., 2016; World Health Organization, 2017).

Evidence-based interventions and service delivery models cannot facilitate recovery in isolation; the context of the individual patient is essential in successfully realising a treatment plan. Scientific evidence should be considered as one, and not the only, important factor in making mental health-care decisions: other factors such as service users’ values, preferences, and choices, are also critically important contributors to mental health-care decisions. Evidence-based practice is often misunderstood or misinterpreted, particularly by many proponents of recovery oriented mental health-care. In reality, evidence based interventions and the recovery approach can go together well, as long as evidence-based interventions are also based on, or enriched by, recovery principles, and scientific evidence is generated on recovery oriented practices. A helpful metaphor to think about the mix of recovery and evidence-based medicine is that of oil and vinegar proposed by Davidson and colleagues (Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009). Recovery and evidence-based medicine are often viewed as oil and water, which cannot mix; however, they should be viewed as oil and vinegar, in that once combined, they make a flavourful vinaigrette.

Implementation of evidence-based interventions can yield better outcomes for service users; however, guidelines alone rarely lead to a significant change in clinical practice. Systematic implementation support is needed to achieve implementation of a new practice, and degree of implementation should be assessed at various points in time using fidelity scales designed to measure key elements in a model. Once a practice is implemented, a quality cycle (i.e. Plan-Do-
Study-Act) (NHS Institute for Innovation and Improvement, 2010) should be introduced to safeguard the quality of care, using service-users reported outcomes. Several strategies need to be combined both on the system level and for clinicians in order to achieve a successful implementation of new practices. It is important to engage leaders on all levels to be involved in the decisions throughout the whole process of implementation. In order to change clinical practice, clinicians must understand and agree on the need to change practice, and receive supervision and feedback frequently over time by supervisors taking part in small group discussions at the local site and communicating results from fidelity assessments and other relevant measures. Study visits and learning from good practices are important to promote innovation.

Here we describe a number of interventions that we regard as good practice for community mental health teams to deliver as interventions. For these good practice interventions, it is important that they are not only effective, but also contribute to a recovery oriented whole team approach. Therefore, they must be relevant for all disciplines in the team.

4.1. Interventions Focused on Reducing Symptoms / Promoting Health

Pharmacological Interventions

Medication is an important element in reducing symptoms associated with mental ill health, as well as to stabilise mood and support functioning (Stahl, 2013). However, medication is never a goal of treatment: it is a tool to help the consumer reach his/her own goals. Medication always has a meaning that may be as important as it’s pharmacological effects. Ambivalence about medication is normal and people will take medication if they feel it will help them and will not take it if they feel it will not help (Diamond, 2011).

Many factors influence the balance between benefits and negative effects of medication, and good practice involves far more than writing a prescription. Medication management for mental ill health can be done in a recovery-oriented way (Diamond, 2011). Close collaboration with the service user in the form of shared decision-making is a critical component of an effective medication regime and treatment program. Some specifics of a shared-decision making plan for medication management include:

- Goals of using medication as a treatment tool;
- Preferences for medication;
- Joint decision on whether to use medication in the treatment plan;
- Joint decision on which medication to use;
- Taking into account the side effect profile, the particular context of the service user;
- Addressing side effects;
- Addressing side effects;
- Managing dosage levels and where possible, prescribe the lowest dosage while ensuring optimal functioning;
- Avoiding polypharmacy
- Medication adherence and corrective actions
- Deciding together on terminating a medication regime and supportive actions.

Tools are available to support the steps in shared decision-making and in monitoring medication regarding the various aspects listed above. Furthermore, we should be more open the the possibility of client’s individual decisions differing from the professional’s opinions, as well as for decisions to reduce or eliminate medication even if that goes ahead with risk of relapses or crises. We see a shift from substituted to supported decisions as a consequence of the UN-CRPD. In addition there are indications that long term psychopharmacological treatment can have a negative impact on social functioning (Wunderink, Nieboer, Wiersma, Sytema, & Nienhuis, 2013).
Psychological Interventions

There are many psychological interventions that have been developed and implemented in community mental health services globally. There is a sizeable evidence base for many of them, and each country may have different recommendations in clinical guidelines, and of course, differing resource availability and training opportunities for specific interventions.

Some psychological interventions are employed in community mental health services more frequently; these include cognitive behavioural therapies (CBT) and motivational interviewing (MI). CBT is the most widely applicable form of psychotherapy that has been proven to be effective on most psychopathology domains (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). The therapist and client collaborate in a personalized shared case formulation to reach the goals of the client and to increase control over symptoms and problems in order to enhance autonomy and self-respect. MI, on the other hand is a collaborative conversation style for strengthening a person's own motivation and commitment to change. It can be used as a conversational technique in clinical practice or as an intervention in itself. The overall style is one of guiding the service user and incorporates elements of directing and following styles. MI regards ambivalence as a normal part of preparing for change. The relational foundation is engaging with a client. Based upon this relationship focusing on specific problems takes place and the therapist evokes the person's own motivation. The focus on collaboration and evoking fit well with the recovery principles and a whole team approach (Miller & Rollnick, 2013).

Increasingly, digital solutions have been created within the sphere of e-mental health that can help the client in their therapeutic journey. For instance, there are a number of e-therapies using apps that guide the person through a series of CBT modules. E-therapies can be administered either in a group or on an individual level, and be moderated/guided by a mental health professional. E-health therapies can be provided as stand-alone guided interventions or blended with traditional forms of care (e.g. a consultation with a general practitioner or psychologist). Most of these interventions are combined with psycho-education, screening and self-management interventions, self-help and peer-to-peer support (e.g. forums, chat groups).
Physical Health Care and Support for a Healthy Lifestyle

Life expectancy of persons with severe mental illness has been estimated to be 15-25 years shorter than that of the general population, and there are indications that this mortality gap is widening (Malina & Rosenbaum, 2016; Olfson, Gerhard, Huang, Crystal, & Stroup, 2015; Walker, McGee, & Druss, 2015).

This shorter life expectancy has a number of possible reasons. Beside less healthy lifestyles and the side effects of anti-psychotic medication, discrimination and social stigma have a strong impact on their quality of life, as it results in low rates of help seeking and poorer quality of physical healthcare among people with mental illness. A well-known concept related to discrimination in health care against people with mental illness is “diagnostic overshadowing”, common in general health care settings (Thornicroft, Rose, & Kassam, 2007). Diagnostic overshadowing is a process by which physical symptoms are misattributed to mental illness, leading to underdiagnoses and mistreatment of the physical conditions. For this reason, it is important that the mental health professionals work together with general health professionals to improve awareness of the impact of stigma related to mental health.

At the same time, the promotion of healthy lifestyles (especially physical activity, healthy food and prevention of smoking) needs to be provided by mental health professionals, in line with health promotion strategies carried out in primary healthcare settings, in order to guarantee the accessibility to this type of care of people with severe mental illness.

The main causes of the high mortality are cardiovascular disease and lung cancer. Smoking is the most important modifiable risk factor, and therefore screening for cardiovascular disease and collaboration with primary care and somatic specialists are essential for community mental health care. Smoking cessation programmes targeted at persons with severe mental illness are an important contribution to physical health (Banham & Gilbody, 2010). The metabolic side effects of antipsychotic drugs increase the risk of cardiovascular disease. Therefore, good community mental health care also involves physical health care, among others by screening patients at risk factors of cardiovascular disease, collaboration with primary and secondary somatic care and organizing smoking cessation programs.
4.2. Interventions Focusing on Social Inclusion

Collaborating with the Family and the Informal Network

Good community-based care utilizes the strength of collaboration with the family and others in a service user's informal network to improve care outcomes. This implies engaging the service user with his or her family and other significant people to be able to understand the service user's context, identifying resources in one's social network, jointly implementing a plan, and following upon progress.

Models for such work with single or multiple families together have been documented as helpful. Family psychoeducation provides carers with information and therapeutic support to better cope with their relative's mental illness and with their own illness-related problems (Lyman et al., 2014; Pitschel-Walz, 2010)

Other promising models for collaboration with family, services and informal network are the resource groups and open dialogue approaches. A resource group is a group of persons selected by the client who help the client to reach his self-defined goals. Within the context of a community mental health service, the resource group meets several times to join and have a shared ownership of the implementation of the treatment plan (Norden, Malm, & Norlander, 2012) In the open dialogue approach family members are brought together during a psychotic crisis for a number of open conversations about the situation of the client. The intention is to support the healthy side of the patient and the family and to normalize the situation instead of focusing on regressive behaviour (Seikkula & Olson, 2003a). Another innovative way to support collaboration with the family network is by providing a lay training in motivational interviewing (Smeerdijk et al., 2012, 2015) Furthermore, interventions directly targeting social isolation can be effective and achieve a meaningful increase in patients' networks (Anderson, Laxhman, & Priebe, 2015)

The user of a community mental health service can also be a person with children with needs related to being a parent. Working with families is therefore also a tool to meet the specific needs of children of parents with mental ill health to reduce the negative impact of parental mental ill health (Leinonen, Solantaus, & Punamäki, 2003; Reupert, Maybery, Nicholson, Gopfert, & Seema, 2015).
Rehabilitation

Users of community mental health services often experience multiple and complex socio-economic problems such as a lack of decent housing, unemployment, poverty, social isolation and loneliness (Thornicroft, Szmukler, Mueser, & Drake, 2011). Community mental health care should therefore not only focus on medical and psychological aspects and interventions, but also on addressing socio-economic issues and identifying the extent to which and way in which people would like to participate and be included in their communities. Rehabilitation is the overarching name for interventions that enable recovery (Holloway et al., 2015). In practice, it is used for interventions that focus on social inclusion. Rehabilitative interventions can be provided by external organisations, or can be provided by community mental health teams. Such interventions enable service users to be part of the community as citizens participating in employment, social and cultural activities (Holloway et al., 2015). It has been empirically proven that service users can be guided to participate effectively in society and can maintain regular jobs. To be able to offer rehabilitative interventions, the first step is to gauge the readiness level of professionals and other members of the community to accept and support people with mental ill health to regain meaningful roles in society.

Several rehabilitation methods have been developed to help people identify and achieve their own individual goals, including living independently, self-care, being successful in competitive employment, participating in routine educational settings, developing better relationships with their families, and pursuing leisure activities. When resources are available, comprehensive methods should be applied which focus on personal goals and wishes of service users. In situations where resources are missing, community mental health teams can still work according to the spirit of these interventions. An example is the motto ‘first place, then train’ that is a characteristic of both Individual Placement and Support (IPS) in which people are supported to gain and stay in competitive employment (Becker & Drake, 2003; Fioritti et al., 2014), or Housing First (Tsemberis, Gulcur, & Nakae, 2004), focusing on obtaining and maintaining decent accommodation. Finally, methods aiming at improving cognitive functioning or practical skills are important, e.g. cognitive remediation training (CRT), and cognitive adaptation training (CAT) (Stiekema et al., 2015).
Supporting Employment

Employment is considered central to human existence, and is identified by many people with severe mental health problems as crucial for their recovery. However, people with severe mental health problems have the lowest employment rates of all disability groups; only 10-17% are enrolled in competitive jobs, while more than half of all of them have the aspiration to obtain employment. Finding a job can be difficult, and maintaining employment can be even more challenging. Consequently, long-term supports are needed to maintain employment that are provided by a multidisciplinary team that understands the broader care context. In addition, supports should be provided at appropriate time intervals that accommodate the service user's needs.

One employment support model for severe mental illness that has been successfully implemented in several European countries (Becker & Drake, 2003; Fioritti et al., 2014) is the Individual Placement & Support (IPS) model. IPS is a psychosocial intervention designed to help people with mental ill health obtain and maintain competitive jobs in the labour market. IPS is recognized as an evidence-based practice, with 24 randomized controlled trials demonstrating its effectiveness over other vocational rehabilitation approaches.

An additional strategy is the development of social enterprises and social cooperatives as integrated offer of train and place contexts in a view of social economy based on principles of solidarity and social inclusion.
**Individual Placement and Support (IPS)**

The IPS model of supported employment advocates a place-then-train approach and long-term support, which only seems to work out well if employment specialists, mental health service providers and regular vocational rehabilitation services cooperate and integrate their efforts.

Critical ingredients of the IPS model are:

- Competitive employment is the goal (whole or part-time)
- No selection criteria, beyond expressed motivation, i.e. accessible to all who want to work (‘zero exclusion’)
- Focus on consumer preference – ‘fitting the job to the person’
- Based on rapid job search and placement. Minimises pre-employment assessment and training - ‘place-then-train’
- Relies on close working between employment specialists and clinical teams
- Provides individualized, long-term support with continuity
- Builds a network of employment opportunities (job development)
- Includes access to expert benefits counselling

One current goal is to make IPS available to young people with first episodes of psychosis. Here it is essential to add education as the second valid outcome of IPS. Research in Australia, United Kingdom, and the United States has shown that the outcomes for this group are promising, and that the potential benefits in terms of careers, symptoms, and social inclusion are substantial.

*Text box 4. Individual Placement and Support (IPS) as best practice.*

**Supported Housing**

A basic need for all is safe, appropriate, and affordable housing, that allows one to maintain independence. Successfully implemented supported housing models provide flexible and appropriate accommodation solutions to take into account the changing and diverse needs of the population, including people with severe mental illness, minority ethnic groups, and women and children. This flexibility and client-centred approach is typically reflected through organisational policies of the supported accommodation service.

To be able to assess needs, supporting housing providers require sufficient information from other care providers to assess suitability and feasibility of providing an individual with an appropriate accommodation solution. An understanding of mental health problems, and some of the more common forms of treatment, will help supported housing staff work effectively with residents who
have mental health problems. Furthermore, building up trust between organizations can minimize the chance of vital information being withheld or lost when making important decisions concerning accommodation. Confidentiality protocols can be used to define the type of information to be shared on a ‘need to know’ basis, and how confidential information can be properly protected.

We recommend that residents are empowered to become involved in consultation and communication with supported housing providers, contributing to the decision-making, management, planning processes and monitoring and evaluation of the organization. User empowerment is a slow and gradual process, and advocates may be needed at first to assist residents to get their views heard.

To reduce risks, supported housing providers need to have effective policies in place to assess and manage risk. To make a proper assessment, the provider needs relevant information about an individual’s present mental state and social functioning, and also about their past behaviour, including violent and risk-taking behaviour. The Housing First approach is more effective than traditional models at dramatically reducing homelessness among those with mental health and substance use disorders.

**Interventions in the Social Sector**

Promising interventions to promote social participation of people with serious mental health problems are identified by Webber & Fendt-Newlin (2017). These interventions are not yet sufficiently known in the mental health domain and include individual and group social skills training and supported community engagement. This shows the potential of intersectoral collaboration: learning from each other in the community.

Research indicates that the relationship between (serious) mental health problems and social adversity is bidirectional. On the one hand, poor, unequal circumstances and social adversity increase risk of poor mental health (social causation). On the other hand, having a mental health condition increases the risk of poverty and being treated in an unequal way (social drift). Tackling this vicious cycle of mental ill-health and poverty is urgent considering that the link between income and ill-health is stronger for mental health than for general health (Wahlbeck, Cresswell-Smith, Haaramo, & Parkkonen, 2017).
Knowing that the relationship between the social and mental health is well-established, Slade (2009) suggested that there are four ways in which clinicians can support an individual’s recovery: not only by offering good treatments, but also by fostering relationships, promoting well-being, and improving social inclusion. However, the promise of social recovery and rehabilitation is not entirely fulfilled in ACT, FACT or in any other community mental health care models (van Weeghel et al., 2011). The social remains, as Johnson (2017) puts it, the poor relative in the biopsychosocial triad when it comes to evidence-based interventions, such as guideline recommendations. There are multiple reasons for this evidence gap (Johnson, 2017). First, the most obvious responses to social determinants of mental ill health, such as poverty and inequality, are political. Furthermore, mental health professionals may feel overwhelmed and powerless in the face of the severe social difficulties that many service users face. In addition, the range of potential targets for social interventions is very wide and extends far beyond mental health services, encompassing individual, family, community and societal levels (van Weeghel et al., 2005). Finally, the dominant professions in mental healthcare research are psychiatry and psychology, with a less developed research workforce in social care.

Still there are compelling reasons to develop and employ social interventions. Most importantly, decades of research on neuroscientific and psychological approaches in mental healthcare have resulted in relatively little evidence of improved outcomes. Furthermore, as already mentioned, the promise of the social lies in our knowledge that it is a powerful influence on both onset and outcomes of mental health problems. In addition, service users advocates focus more on goals that include reducing stigma and social exclusion, and promoting good relationships and support within communities. In trying to achieve these goals, there are substantial benefits in establishing an evidence base for social interventions rather than relying on interventions that may work. Without robust evidence, including health economics, it is difficult to make a strong case for funding social interventions, or for prioritizing them in guidelines (Johnson, 2017).

Wahlbeck et al. (2017) made an inventory of intersectoral interventions on various levels to counteract the negative effects of poverty, inequality and social exclusion. They describe life course interventions (e.g. parenting support programmes, health visitors, school programmes, mental health promotion for older individuals); household interventions (e.g. rental assistance
programmes, Housing First); working life interventions (IPS; Job Search Groups); interventions at community level (e.g. targeting social exclusion and digital exclusion); interventions at services level (e.g. better access to health care; ‘social prescribing’; depts advice and financial counsellors); and policy level programmes (e.g. access to primary health care; housing and urban planning; labour policies; social policies; ‘Youth Guarantee’ approach; debt relief policies).

Promising interventions to promote social participation of people with serious mental health problems are identified by Webber and Fendt-Newlin (2017) presented in the box below.

Interventions to promote social participation

- Individual social skills training
- Group skills training
- Supported community engagement
  - Supported Socialization
  - Urban project
  - Independence through Community Access and Navigation (I-CAN)
  - Social Network Intervention
  - Connecting People Intervention
  - Group homes plus GGz-hulp
  - Friends Intervention
- Group-based community activities
- Employment interventions
- Peer Support interventions

Text box 5. Interventions to promote social participation.

On the same note, Mann et al. (2017) reviewed studies on interventions to reduce loneliness in people with mental health problems. They conclude that as yet, no types of intervention have a robust evidence base. Promising future approaches may include: public health initiatives to create
accepting communities, better designed psychological intervention studies, greater use of digital technology and programmes to link people with supportive social activities, and opportunities within local communities.

All of these must be considered in the context of wider social policies, including housing, employment, welfare benefits, and infrastructure, to support forming meaningful social relationships that may improve health outcomes and quality of life for people with mental health problems. The effects of inequality and poverty on health and well-being are increasingly clear. Alongside the development of social interventions as described above, there is a compelling case for investment in national and local policies that directly target the roots of mental ill-health (Smith & Eltanani, 2015).

4.3. E health and M health

In today’s world, fixed structures are being increasingly replaced by volatile and flexible connections, requiring more and more the ability to adjust to changing circumstances. In this network society, the relationships of the past can no longer be taken for granted and new forms of self-organisation emerge. Mental health care will have to find a way to deal with this society change with internet and social media in which an increasing number of citizens are part of e-communities. This creates both opportunities and threats for the treatment persons with mental ill health. E Health is using the information and communication technology to improve mental health care. M health is the use of mobile devices for this purpose (https://mastermind-project.eu). In a review Naslund et al. (2015) show the feasibility and acceptability of emerging mHealth and E Health interventions among people with severe mental illness. However, it is not possible to draw conclusions regarding effectiveness. Further rigorous investigation is warranted to establish effectiveness and cost benefit in this population (Naslund, Marsch, McHugo, & Bartels, 2015)

Advantages for the patient are that it enables the self-management of treatment, independent of place and time, doing a treatment in his own environment without travelling and time in waiting rooms while having unlimited access to peer support.

Threats are the dependence on technology, the lack of sensory input (which is among others a diagnostic tool) and the unresolved ethical and legal issues regarding safety, privacy and
accountability. These issues will have to be resolved as modern community mental health cannot be imagined without E health and M health. It is important that community mental health teams are early adopters and see the e-community as their natural environment. It is important to make a distinction between programmes that were designed as a part of a blended therapy and self-help tools.

Self-help e-interventions that exist in the mental health space have the potential of strengthening self-management. Apps can be downloaded that address a multitude of problems such as depression, PTSD, anxiety, and guide the user through exercises, information, and logging mood and feelings in the app helping as a complement to traditional therapy or as a standalone intervention.
5. The Community Network Perspective

Figure 5. Like a beehive, community mental health is a network itself that operates within a broader network of self-help, family, friends and other informal resources and generic community services. Cross pollination is a symbol for interdisciplinary collaboration.
CONCLUSIONS AND RECOMMENDATIONS ON THE COMMUNITY NETWORK PERSPECTIVE

- Community mental health, care is a combination of input and supports from users, people from the user’s social network, and professionals when needed.
- A community mental health service is a network within a broader network of self-help, family, friends and other informal resources and generic community services.
- Community mental requires interdisciplinary and intersectoral collaboration.
- Primary care practices play a central role in the community mental health care model and provide care for people with a mental illness and their network.
- There are several domains of integration in community mental health care: integration of medical and social interventions, integration of community and hospital teams and integration between different mental health service teams (e.g. dual diagnosis treatment).
- Common elements of community mental health service delivery models include a multidisciplinary team, ability to upscale or downscale care when needed, home-based care or care where the client needs it, focus on social and mental health care and a close collaboration with the psychiatric hospital in case of admission.
- The transition to community mental health care can be hindered by a financing system that favors institutional care (e.g. by rewarding bed occupation). The introduction of a prospective, program oriented financing system within the mental health care setting is recommend, favoring interdisciplinary and intersectoral collaboration.
- The scope of community mental health is not restricted to severe mental illness (or psychosis) but includes all mental health needs – e.g. by being available for the family doctors in the region.
In community mental health, care is a combination of input and supports from users, people from the user’s social network, and professionals when needed. The aim of this combination of perspectives in care is to bridge the gap between professionals and non-professionals, in order to increase the resilience of users as well as the resilience of the networks around users. A number of essential functions must be developed within a network of mental health and social services in a defined geographical area. Deinstitutionalization and the introduction of community mental health also implies reform and improvement of social services. Rules and legislation can hinder recovery, by rewarding remaining ill, or marginalizing those who try to participate (e.g. the risk of losing their indemnities). Financial incentives can also be in favour of using the available resources for hospital admission and not for community care.

A network of community-based mental health services has a central node that coordinates work and information in the network, typically consisting of a multidisciplinary, multi-service therapeutic care network that can provide a broad spectrum of flexible interventions tailored to needs of users, which will ultimately allow people to recover in their home environment with support from their social network. Depending on the resources available, these domains can be organised as separate teams or functions of more generic teams. Separate teams allow for specialization, yet also bear the risk of fragmentation of resources. The risk of fragmentation can be minimised through implementing strong connections between disciplines and services. It is

**Figure 6. Framework of support (Trainor & Church, 1984)**
important that the different disciplines in a community mental health team take a shared responsibility for the interventions. This implies an interdisciplinary and a multi-expert way of working in which there are no exclusive domains. Expertise varies per discipline, and it is a task of the experts in the team to share their expertise, e.g. by organising clinical lessons. Furthermore, the professional expertise of team members is combined with the lived experience of users. The same principle is the case for the intersectional collaboration with others other types of services.

The following teams or functions should be provided in a comprehensive community mental health service:

5.1. **Integration of Mental Health into Primary Care**

Many preventive interventions (e.g. e-mental health tools) can be used within the context of the home environment of the user. Early identification of mental health problems (including screening and diagnosis) can be done in primary care by general practitioners in collaboration with specialized care professionals. General practitioners often have a long-term continuity of treatment and are the gatekeeper for specialized care, as they are often the first point of entry for a health problem in many European health systems (Bower & Gilbody, 2005). As such, general practitioners have important roles in referring patients to specialized mental health services, providing integrated care for physical and mental health for co-existing conditions (e.g. diabetes and depression) (Holt, De Groot, & Golden, 2014), and to serve as the linking pin between specialized care, primary care and social services. Close collaboration may provide early intervention for many patients whose emerging mental problems have not yet manifested or been recognized.

Close collaboration between general practitioners and community mental health teams in a regional network may also increase the skills in treating mental illness in primary care. Common goals, clear and equitable decision making and open and regular communication are key elements for good collaboration. In contexts with limited resources, it is even more important that mental health services prioritize collaboration with primary care and provide support to primary care providers and social services, who may have more frequent contact with service users (McDaid et al., 2007). Mental health care provided in primary care, as at all levels of care, should emphasize the service user perspective, adopt a shared decision-making approach and support personal recovery.
5.2. Outreach Teams Offering Intensive Treatment for both Acute and Long-Term Mental Health Problems

This function relates to treatment teams that operate in the community and provide treatment in the context of the service user's home environment. Here, home visits form a routine part of care, ensuring rapid access to care. Close collaboration with primary care providers brings mobility and expertise to these services. The teams must be embedded in the community and work in close collaboration with other sectors like employment, accommodation and leisure. Care in the community is flexible, team based and uses various forms of engagement.

Crisis Resolution Teams and Emergency Mental Health Care in the Community

Easy access to emergency mental health care in the community for people with a mental health crisis is an important part of community mental health care. GP's, preferably on call 24/7 are an important cornerstone in emergency mental health care in the community. Crisis Resolution and Home Treatment Teams (CRT's) are a service for adults experiencing an acute mental health crisis who would otherwise require hospital admission. CRT's aim to provide rapid assessment, to treat service users at home where possible, and to facilitate early discharge from hospital. They offer an alternative to hospital care with the aim of assessing and treating people 'in the least restrictive environment with the minimum disruption to their lives'. Key elements in this model are accessibility, intensive support and a "gatekeeping" function by controlling access to inpatient beds, enabling admissions when necessary and avoiding hospitalisation when possible. A core task of CRT's is assessing the feasibility of home treatment before admission.

Early detection and intervention is crucial to keep young patients in their social surroundings, family, school, job and leisure, to ensure they can continue to develop themselves build up resilience. This early intervention must be multidisciplinary and should have an emphasis on psychiatric, psychotherapeutic and social and assertive intervention at home, but also in school and profession. Early detection and phase-specific treatment may both be offered as supplements to standard care, or may be provided through a specialised early intervention team (Marshall & Rathbone, 2011)
Models for CRT’s and other special teams like assertive outreach teams and early intervention teams have mostly been developed in urban areas where the number of service providers and the population size makes it possible to have specialized teams for different groups of service users. Service delivery in more rural areas may require a different approach, such as outreach teams that have different functions and serve several target groups. In countries or situations with less resources, GPs and primary care can provide emergency care with support from mental health care.

Outreach and Integrated Care for People with Serious Mental Health: Act and Flexible Act

People with serious mental health problems can live and function in the community, provided they receive sufficient support and treatment. A multidisciplinary team is needed to provide broad and comprehensive services, including treatment and management of illness and symptoms, guidance and practical assistance with daily living, rehabilitation and recovery support. Well described models are Assertive community treatment (ACT) and Flexible ACT (see box) An integrated team can provide all of these functions with the patient in his or her own environment. Practitioners working in the community are more likely to see the strengths and supports of clients, what their talents and hobbies are, where their skills lie and what supports are available in their environment. Furthermore, there is the opportunity to meet the client’s family, and confidentiality can be maintained. The clients can demonstrate what they can and cannot manage, what assistance they need and solutions and strategies can be developed together. ACT also offers significant advantages over standard case management models in reducing homelessness and symptom severity in homeless persons with severe mental illness. (Coldwell & Bender, 2007) There is emerging, but as yet inconclusive evidence, to suggest that people in the prodrome of psychosis can be helped by early intervention (Marshall & Rathbone, 2011).
Models for CRT's and other special teams like assertive outreach-teams and early intervention teams have mostly been developed in urban areas where the number of service providers and the population size makes it possible to have specialized teams for different target groups of services users. Service delivery in more rural areas may require a different approach, like outreach teams that have different functions and serve several target groups. In countries or situations with less resources, GPs and primary care can provide emergency care with support from mental health care.

**Assertive Community Treatment (ACT) and Flexible ACT (F-ACT)**

Assertive Community Treatment (ACT) is an evidence-based practice that improves outcomes for people with severe mental illness who are most at-risk of homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system. ACT is one of the oldest and most widely researched evidence-based practices in behavioural healthcare for people with severe mental illness. ACT is a multidisciplinary team approach with assertive outreach in the community. The consistent, caring, person-centred relationships have a positive effect upon outcomes and quality of life. People receiving ACT services tend to utilize fewer intensive, high-cost services such as emergency department visits, psychiatric crisis services, and psychiatric hospitalization. They also experience more independent living and higher rates of treatment retention.  

A Dutch version of ACT is Flexible ACT (F-ACT). The multidisciplinary 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
2. Intensive (ACT) team care, which involves a shared caseload, having contact with several team members; these clients are listed on the Flexible Assertive Community Treatment (FACT) board and the team discusses them every day to decide which form of care should be provided and by which team members.

As a result, the client can receive care every day or even several times a day.

*Text box 6. ACT and F-ACT as good practice.*
5.3. **Dual Diagnosis Treatment**

Dual diagnosis treatment is integrated care that addresses needs arising from addiction problems in combination with other mental health problems. Good practice examples of dual diagnosis treatment include the integrated dual disorder treatment (IDDT) (Boyle, Delos Reyes, & Kruszynski, 2005; Drake et al., 2001; Frisman et al., 2009). Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime. Therefore, within specialty mental health and substance use clinical settings, it is the norm rather than the exception to see consumers with co-occurring disorders. Lacking recognition of the high prevalence of co-occurring disorders, agencies that develop specialty teams to treat small groups of consumers with co-occurring disorders, consequently, leave many consumers undiagnosed and untreated. IDDT is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance-use disorders by combining substance abuse services with mental health services. IDDT helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. Practitioners develop integrated treatment plans and treat both serious mental illnesses and substance use disorders so that consumers do not get lost, excluded, or confused going back and forth between different mental health and substance abuse programs. People with mental ill health receive one consistent, integrated message about substance use and mental health treatment. Integrated treatment specialists have knowledge of both substance use disorders and serious mental illnesses and understand the complexity of interactions between disorders. They are trained in skills that have been found to be effective in treating consumers with co-occurring disorders.
5.4. Intensive Residential Treatment for People with Acute and Enduring Mental Health Problems

Intensive residential treatment (IRT) is a short-term care option in episodes when care provided at home is not practical or beneficial (Thomas & Rickwood, 2013). At these moments people with severe mental health problems may experience advantage of being admitted to a hospital, in particular when damage to self or others cannot be stopped or prevented in an ambulatory setting.

IRT typically consists of a set of small units with short stay options as well as units that provide intensive and frequent around-the-clock care provided by specialized staff. We recommend that these facilities are an intermezzo in a community treatment. Important elements to support this principle are the presence of well-defined criteria for admission, early and timely discharge, and follow-up by the community team closest to the patient for continuity of care. Mobile teams can perform the treatment in these settings, which is described as ‘inreach’. The link with the patient’s social network is maintained to optimize the early return to the home environment and maintain integration within their community.
6. The Peer Expertise Perspective

Figure 7. Kintsukuroi is a Japanese tradition in pottery, “to repair with gold”, understanding that the piece is more beautiful for having been broken. Peer experts can be described as persons with lived experience who have turned their mental ill health into gold.
CONCLUSIONS AND RECOMMENDATIONS ON THE PEER EXPERTISE PERSPECTIVE

- Clients and service users are equal partners in the design, delivery, steering and evaluation of a service. ‘Nothing about us without us’.
- At the individual level, shared decision making is a tool for co-creation of treatment planning.
- Peer experts are an indispensable part of mental health teams.
- Other professionals can use their own experience as a tool in their relationship with clients.
- On a policy level service users are partners in the design and evaluation of services.
Peer expertise plays an important role in the process of recovery. Peer experts are the living example that recovery is possible and can support other professionals to use self-disclosure as a tool to support their clients (Repper & Carter, 2011; Solomon, 2004). Therefore peer expertise can be regarded as a third domain of expertise, in addition to scientific evidence and practice skills. Peer experts can play a role in community mental health teams, services and at a policy level.

Co-creation of care is where service users, peer supporters and staff work together as equal partners to design, deliver, steer and evaluate a service, ensuring that people with lived experience lead the way. It is the recognition of the importance of peer expertise as one of the foundations of recovery oriented care. It is a form of self-advocacy, in which service users themselves say what they want, secure their rights, represent their interests and obtain services they need and thus are partners in creating care.

Having acknowledged this, it means a lot of effort and organization to build this expertise and organize this level of involvement. First of all, it requires that service users and their carers are empowered to take a step in building this expertise contributing to the mental health sector. The empowerment process requires action at the individual level, the service provider level and the broader community level.

Co-creation starts with providing resources to develop user-led services, including representative organizations that give input to public and political activities and are active at the (inter-)national, regional and local levels, offering (ex-)service users the possibility to develop their expertise. Developing the expertise is done by sharing own experiences, learning from other service users and by reflecting on and integrating these experiences. In many countries, special trainings/courses have been developed to become an expert by experience (for example http://www.researchintorecovery.com/conferences-training-and-consultancy).
Individual level (treatment)

Co-creation at the individual level means that the service user is a partner in all decisions concerning treatment, setting recovery goals, and formulating/evaluating treatment and recovery plans. A shared-decision making approach is used, meaning that the service provider together with the user, review clinical and practice-based guidelines as well as leverage both their expertise in reaching a joint decision on care.

“I experienced my psychiatrist’s insistence on my compliance with medication as oppressive. His stance left little room for me to name my experience. It relegated me to the role of a passive patient, an object to be acted upon, rather than a human subject who, in acting, could change my life. I was dehumanized in this interaction because my choices were framed as obedience or disobedience to medical authority, as opposed to understanding that my choices reflected freedom, autonomy and the self-evident right to determine what happened to my body” (Deegan 2007).

Shared decision-making is a person-centred model, founded on the premise that there are two experts: the practitioner and the client. As a consequence of UN-CRPD, this probably can better be replaced by supported decision making. Neither of these parties should be silenced, and both must share information in order to arrive at the best treatment decisions possible. In this joint decision-making construct, it is recognised that practitioners have expertise in more medical diagnostics and treatment, as well as in-depth knowledge on evidence-based approaches; clients, on the other hand, have expertise by virtue of the lived experience of their disorder, and their intimate knowledge of what gives their life value, meaning, purpose and quality (Deegan, 2007) It should be noted that each element of the shared-decision making process should be linked to not only clinical goals but life goals and recovery goals as well. This would mean shifting away from a goal such as “I want to be less anxious” to “I want to be less anxious so I can ride a bus and go to work.” This allows other non-medication, non-symptom relief interventions to be integrated into the plan. Core dimensions of shared decision-making include (Salyers et al., 2012):

- Discussion of the service user’s role in decision making;
- Discussion of the service user’s goal and the context of the decision;
- Discussion of the clinical issue or nature of the decision;
- Discussion of the alternatives; non-medication alternative present (yes or no);
- Discussion of the pros and cons relevant to the decision;
- Discussion of uncertainties associated with the decision;
- Assessment of the service user’s understanding;
- Assessment of the service user’s desire for others’ input;
- Exploration of the service user’s preferences.

**System Level (service or team level)**

Increasingly, meaningful collaboration with people who use - or have used - services is being recognized as an indispensable part of mental health service delivery. Peer support means that someone uses his/her own lived experience to support another person experiencing mental distress. When people are equipped and supported to help commission, deliver and check the services they and their peers use those services improve and the people involved gain in confidence and skills. This creates more user-led services, organizations or programs where service users have the majority of decision-making power at every level. There are numerous tools available which focus on the co-creation of good quality mental health services by users, carers, service providers, and managers. The WHO Quality Rights Toolkit is one such example of a framework that systematically includes the preferences and input of service users and carers in each phase in the quality improvement process (World Health Organisation, 2012).

Some professionals in the team also have experiences with mental health problems. The presence of peer experts in the team raises the issue that they also can use their experience in a professional way as a tool in their relationship with the services users. This has given a new interest in the use of self-disclosure by professionals in the mental health teams (Marino, Child, & Campbell Krasinski, 2016; Self-disclosure, 2001)
Policy Level (laws, policies and plans)

On a policy and system level, service users and their close ones are architects in the design and evaluation of services. Service user involvement is about making sure that mental health services, organizations and policies are led and shaped by the people best placed to know what works: people who use mental health services. This means that working groups for setting policies of hospitals, services, or regulations in a health system should include service users, either independently or via service user associations. Furthermore, in a more advanced stage of policy and law development, it is essential that stakeholder consultations for draft policies and laws are circulated for input of service users and carers.
Conclusions

This consensus paper describes the fundamental principles and elements of good community-based mental health services. For each element or perspective, criteria or recommendations have been made to further specify what good community mental health care looks like.

The six perspectives have been translated in this document to 6 principles underpinning the organisation of community mental health care.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Principles</th>
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<tr>
<td>Ethics</td>
<td>Human rights</td>
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<td>Public health</td>
<td>Addressing the needs of the population,</td>
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<tr>
<td>Recovery</td>
<td>Building on personal goals and strengths</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Interventions based upon needs</td>
</tr>
<tr>
<td>Network</td>
<td>A wide network of services and resources</td>
</tr>
<tr>
<td>Peer expertise</td>
<td>Patient is cocreator of care</td>
</tr>
</tbody>
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In this final chapter, we list the conclusions and recommendations that we have given for each of the 6 perspectives.
1. *Ethics Perspective*

- The focus on human rights is a fundamental principle in community mental health care: the right of access to needs based care in the least restrictive environment and the right of full participation in community life. This includes civil rights, citizenship and cultural, spiritual, sexual and political freedom.
- Ensuring the right to mental health care in legal and policy documents is an essential strategy for enshrining the rights of persons with mental ill health in practice.
- We recommend that mental health services base their mission and vision on the United Nations’ Convention of the Rights of Persons with Disabilities (CRPD, 2008) that sets out the right to live, participate in the community, education, health, employment, housing and social protection.
- Providing training and coaching for staff of inpatient mental health care settings on recovery and rights is a helpful step to reducing human rights violations that occur in the context of mental health services.
- The Quality Rights Toolkit of the WHO offers a training framework for assessing and improving quality of mental health services.

2. *Public Health Perspective*

- Community mental health services work for the health of all citizens in their catchment area. Not only those who are registered as clients, also those who may become clients, those who need care but are hard to engage and those who don’t need specialized mental health care but benefit of the presence of community mental health services e.g. by support to the general practitioners.
- Addressing mental ill-health in the community means not only treatment and care but also prevention and promotion of good mental health. Taking actions to eliminate discrimination and reduce stigma are essential.
- Community mental health care works with multidisciplinary teams in well-defined regions. The size of the region depends on the regional demography, prevalence of mental ill health and the resources of mental health care. It is a trade-off between the advantages of a small
region (ability to be present, collaboration with a small number of family doctors) and the necessity of sufficient resources to form a multidisciplinary team.

- Concepts of community mental health care were developed for the treatment of persons with severe and persistent mental ill health, yet apply to all mental health needs (and beyond).
- Mental health is a public health issue (relevant to high numbers of citizens in the population). It requires of mental health services to provide a recovery oriented approach and presence in the community.
- Care for persons who are hard to engage is a core task of community mental health teams.

3. Recovery Perspective

- Recovery is the client’s journey, and the task of mental health professional is to support and not to hinder this journey.
- People can and do recover even from the most serious mental health problems
- Community mental health teams focus on recovery of health, social functioning and personal identity.
- We describe 10 ways to support recovery. The most important one is offering hope.
- Recovery-oriented care entails focusing on strengths of the service user and leveraging the existing resources around the client, however big or small those resources may be.

4. Effectiveness Perspective

- Effective interventions are an important tool of community mental health services to support recovery of their clients.
- The task of community mental health services is to provide evidence informed context based mental health care.
- Effectiveness of interventions is defined in addition to scientific evidence by: being well defined, reflecting client goals, durable outcomes, reasonable costs, adaptability to diverse communities and feasibility of implementation.
- Evidence based medicine and the recovery attitude are not of different camps and can be compared to oil and vinegar: two approaches that can be combined very well and together make a tasty vinaigrette.
Recommended interventions reducing symptoms are psychopharmacology, cognitive behavioural therapy and motivational interviewing.

Good community mental health care involves somatic screening and support of smoking cessation.

People increasingly participate in e-communities. Therefore, we recommend that community mental health collaborate with their clients using digital interventions with e-health and m-(mobile) health tools.

Recommended interventions to improve social functioning individual placement and support (IPS) and Housing first. In general, the social inclusion is best supported by a first place then train approach and learning in practice.

5. **Community Network Perspective**

- Community mental health care is a combination of input and supports from users, people from the user's social network, and professionals when needed.
- A community mental health service is a network within a broader network of self-help, family, friends and other informal resources and generic community services.
- Community mental health requires interdisciplinary and intersectoral collaboration.
- Primary care practices play a central role in the community mental health care model and provide care for people with a mental illness and their network.
- There are several domains of integration in community mental health care: integration of medical and social interventions, integration of community and hospital teams and integration between different mental health service teams (e.g. dual diagnosis treatment).
- Common elements of community mental health service delivery models include a multidisciplinary team, ability to upscale or downscale care when needed, home-based care or care where the client needs it, focus on social and mental health care and a close collaboration with the psychiatric hospital in case of admission.
- The transition to community mental health care can be hindered by a financing system that favours institutional care (e.g. by rewarding bed occupation).
- The scope of community mental health is not restricted to severe mental illness (or psychosis) but includes all mental health needs – e.g. by being available for the family doctors in the region.
6. Peer Expertise Perspective

- Clients and service users are equal partners in the design, delivery, steering and evaluation of a service. ‘Nothing about us without us’.
- At the individual level, shared decision making is a tool for co-creation of treatment planning.
- Peer experts are an indispensable part of mental health teams.
- Other professionals can use their own experience as a tool in their relationship with clients.
- On a policy level service users are partners in the design and evaluation of services.

Table 2. What have we achieved, what are the hopes and what are the risks?
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