SPECIAL ISSUE
Community Psychiatry

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Sacrifice in Black and White
Assaf Ronen

The light of the sacrifice is in shades of black and white.
The struggle with memory is one's journey to recovery.

Editorial: Mental Health Reform and a Window of Opportunity for Community Mental Health

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A major landmark in health delivery in Israel was the implementation of the Israeli National Health Insurance Law (NHIL) in 1995 which entitled every Israeli resident to health insurance. Coverage is provided by four health funds, which serve as insurers and providers of services. Health funds receive capitated payment from the government and are accountable for their members' health across the life span. Although originally mental health (MH) services were intended to be provided as part of all health fund services, this provision was maintained by the government for over 20 years, sustaining the artificial split between mental and other health services.

In July 2015 the State of Israel transferred the responsibility for mental health services from the Ministry of Health to the four not-for-profit Health Maintenance Organizations (HMO). This mental health reform is perhaps the most dramatic event in Israeli health services since the implementation of the NHIL, creating the mechanisms by which hospital and community MH services are now covered by the four health funds that operate as HMOs throughout the country.

The reform seeks to improve mental health by clarifying and specifying the legal right to care, and by improving the availability, accessibility and efficiency of services. In addition, it is hoped that the reform will help reduce the stigma associated with mental health service use by creating a more holistic and integrative delivery of services, and putting to rest to the long history of mental health services being different and separate.

In the preparation period towards this reform (2012-2015), the HMOs opened approximately 60 new clinics across the country with a greater emphasis on their integration within other health services. A critical element of the reform is that the HMOs are required now to pay for the psychiatric hospitalizations of its insured members, for which they now receive capitated payment. This created a strong incentive for HMOs to invest in prevention, alternatives to hospitalization, and rehabilitation, giving a strong push to community mental health.

In this context, we are delighted to act as guest editors for this special issue of Community Mental Health, at this historical point in the reform of mental health services in Israel.

Indeed much can be learned from efforts to implement community care in different countries and settings. This issue of Community Mental Health presents three papers on the need for new and better paradigms for enhanced community mental health care. Two examples are presented of community intervention programs to provide mental health services and to facilitate community integration and participation, one study about an academic seminar to train and prepare future community leaders to promote mental health within the Israeli-Arab community, one discussion of discharge programs as essential for the promotion of community integration, and two studies on the role and capabilities of primary care physicians in the provision of mental health services in the community.

In his thought-provoking article in this issue, Gerald N. Grob takes us on a critical journey of the history of psychiatric service provision in the U.S.A. from the origins of the deinstitutionalization movement to the current challenges to the community mental health care model. He provides a description of how ideology without scientific evidence lay behind the new community policy, he analyzes the consequences of the enactment of the Community Mental Health Centers (CMHC) Act in 1963, and he explains how these policies produced the paradox of deinstitutionalization. The author discusses several assumptions that were made at the time and were proven erroneous (i.e., living in the community would necessarily promote integration, or

that CMHCs would assume responsibility for aftercare and rehabilitation), along with other shortcomings in the implementation of the model. He argues that while the concept of community care and treatment were not essentially flawed, they were plagued by a disregard of the need for social support systems, housing, occupation and income for those people whose illness may impair their independence. He discusses the policy implications of what has been learned in the U.S.A. to help inform policy reform in Israel.

Rowe et al. (this issue) provide a new paradigm to community mental health (CMH) care, from the definitions of the term "recovery" and the different visions of "recovery" to the concept of "citizenship" and "citizenship-oriented care." The authors provide a shift in concepts from two forms of recovery for persons with mental illnesses – clinical recovery (recovery as an outcome), and recovery as a process of regaining personal purpose, to a more integrative concept of recovering citizenship which suggests that individual recovery can be achieved through access to the 5 Rs (rights, responsibilities, roles, resources and relationships) and belonging, based on the logic that "you don't have to wait to recover in order to become a citizen" and using psychiatric rehabilitation approaches and advocacy to achieve it.

Longden et al. (this issue) argue that the shift to community care has as yet failed to facilitate a more recovery-focused approach as it has imported the medical model used in psychiatric hospitals, including coercion techniques. They advocate for deep-seated changes in order to develop evidence-based services that will both scientifically and ethically be capable of responding to patients' needs in a more compassionate and effective way. The authors provide examples of approaches that are prepared to implement the necessary paradigm shift in both academic theory and therapeutic practice. This provocative and inspiring paper is further enriched thanks to the thoughtful comment by Yanos et al. (this issue) that signifies the starting point of a constructive dialogue.

Cai and Fung (this issue) present a retrospective review of the Response, Early Assessment and Intervention in Community Mental Health (REACH) program from its inception in 2007 until February 2015. This is a community-based mental health program working with schools and other partners to provide mental health services for youths in Singapore, in which interventions are focused on training and empowering school-based personnel to work with students and the family, with the support of the REACH teams. The authors provide a detailed account of the methods, implementation steps, piloting, team composition and training, network and support building. They also report their evaluation results, including treatment outcomes, consumer satisfaction and cost effective analysis. They provide evidence that a cost-effective population-based community mental health programs with schools can be implemented nationally through a multi-sectoral, stepped approach, and that it can provide good services which improve youth outcomes.

Hasson-Ohayon describes the reform as an opportunity for a re-consideration of the discharge process from psychiatric hospital to the community. She reviews the unmet needs of persons with serious mental illness (SMI) at discharge, and she summarizes the interventions aimed to ease the return to the community and argues in favor of implementing these in Israel.

Burns-Lynch et al. (this issue) present the results of a study to explore how far efforts to facilitate community participation (i.e., work, leisure, social inclusion) may enhance recovery and quality of life in people living with SMI. Results based on 606 study participants revealed statistically significant positive relationships between community participation, recovery and quality of life. Most important, specific participation areas which respondents perceived as important were associated with recovery and quality of life. The authors discuss the implications of these results on the need for interventions to support increased community participation among people living with SMI to promote recovery and improve quality of life, along with possible directions for future policies and practice,.

Khatib et al. (this issue) describe an innovative initiative aimed to facilitate Arab masters (MA) students to develop integrated cultural competencies, and to act to promote mental health within the Israeli Arab community. This initiative took the form of an Arabic speaking university seminar that strove to bind the students' familiarity with Arab culture with reading materials and research literature on mental health issues and practices from the Arab world. The academic setting is described as a nourishing and facilitating environment for training and preparing future community leaders who will bring about social change in mental health issues.

Hornik-Lurie et al. (this issue) report the results of a study which examines whether a specialization in family

medicine, compared to other specializations in primary care physicians (PCPs), enhances physicians' ability to detect, diagnose and treat mental health (MH) problems in community general clinics in Israel. The authors report that physicians with a specialization in family medicine were more likely than other PCPs to detect, diagnose and treat MH problems. The characteristics associated with better identification and stronger self confidence to assume treatment responsibilities of MH problems are described and discussed as well as the implications for the future.

In their article, Avny et al. (this issue) evaluate the advantages and disadvantages of a model in which psychiatrists provide consultations twice a month at the primary care clinic to clients referred by their family physicians, from the perspective of the latter. The authors conclude this model was preferred to the existing model by the majority of PCPs, and was perceived to be superior in terms of clients' adherence and in terms of reducing workload in caring for the referred clients. The model is discussed in terms of advantages for better diagnosis and treatment of psychiatric disorders in particular for the more prevalent depression and anxiety disorders in the community.

Taken together, the papers in this special issues of Community Mental Health present a rich feast of historical and policy analysis, research evidence and lived experience which can be used to wisely inform better mental health in Israel in future,

Community Mental Health Policy in America: Lessons Learned

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ABSTRACT

After 1945 the prevailing consensus that persons with serious mental disorders should be treated in public hospitals began to dissolve. It was replaced by a faith in the efficacy of community care and treatment. Yet for a variety of reasons the new community care system fell far short of its initial promise. Advocates failed to understand that the problems of persons with serious and persistent disabilities were different from those people with mild and moderate disorders. The belief that residence in the community would promote adjustment and integration was illusory and did not take into account the extent of social isolation, exposure to victimization, inducement to substance abuse, homelessness, and criminalization of persons with mental disorders. Effective community care for those previously kept in hospitals must make up for the range of functions that hospitalization was intended to provide, from housing and supervision to treatment and rehabilitation.

INTRODUCTION

Before 1945 public policy in the United States was based on the belief that the proper place for persons with severe disorders was in state mental hospitals. By then the average daily resident population was about 430,000; a decade later the number peaked at 558,000. As late as 1958 nearly a third of all state hospital resident patients were over the age of 65, thus confirming a widespread impression that such institutions were largely custodial rather than therapeutic in their character (1).

Few public policies, however long established or stable, remain immune from broader social, economic, intellectual and scientific currents. Beginning with World War II, the faith that institutionalization was the appropriate policy choice began to erode. Within two decades the very legitimacy of mental hospitals had been undermined by individuals and groups committed to a new policy paradigm, namely, that the care and treatment of persons with severe mental disorders should take place in the community. By 2005 the number of institutionalized patients had fallen to less than 50,000; the overwhelming majority of persons with severe disorders were now treated in community general hospitals or other outpatient facilities (2).

ORIGINS OF A COMMUNITY POLICY

What accounts for such a dramatic policy shift and what were the consequences of the transition from an institutional to a community-oriented policy? The answers to these questions are by no means simple. The changes in postwar mental health had diverse roots. The military experiences of World War II allegedly demonstrated that community and outpatient treatment of persons with mental disorders was superior and more efficient. A simultaneous shift in psychiatric thinking fostered receptivity toward a psychodynamic and psychoanalytic model that emphasized life experiences, the importance of socioenvironmental factors, and psychotherapy of one form or another. The belief that early identification of individuals at risk and intervention in the community would be effective in preventing subsequent hospitalization became popular. This belief was especially encouraged by psychiatrists and other mental health professionals holding a public health orientation. They also shared a faith that psychiatry, in collaboration with other social and behavioral sciences, could ameliorate those social and environmental conditions that in their eyes played an important role in mental disorders. The introduction of new psychosocial and biological therapies – includ-

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ing but not limited to psychotropic drugs – held out the promise of a better and more productive life for persons who in the past were institutionalized. At the same time psychiatrists abandoned mental hospital employment for private and community practice. Finally, a series of journalistic and media exposés seemed to confirm the belief that mental hospitals were simply incarcerating persons and providing little in the way of therapy (3).

A crucial element in hastening change was the growing role of the federal government in health affairs. The passage of the National Mental Health Act of 1946 and subsequent creation of the National Institute of Mental Health (NIMH) was of major importance in hastening change. The act was conceived and orchestrated through Congress by Dr. Robert H. Felix, who served as the first director from 1949 to 1964. One of the shrewdest and most effective federal bureaucrats of his generation, Felix worked to end institutional care and employ federal prestige and resources to create a new community-oriented policy. He framed a national agenda that assumed that community care and treatment, as well as preventive efforts, would replace archaic mental hospitals (4).

During the 1950s interest in community alternatives to mental hospitalization mounted. The development of psychosocial, milieu and psychotropic drug therapies gave impetus to the belief that early identification and treatment in the community would obviate the need for hospitalization. Support for such a program came from a variety of constituencies. The Council of State Governments and Governors Conferences in the 1950s endorsed this approach as a means of arresting the seemingly inevitable growth of the institutionalized population. Private foundations such as the Milbank Memorial Fund as well as leading university departments of psychiatry added their voices to the chorus promoting change. The growing faith in community mental health led New York State in 1954 and California in 1957 to enact legislation encouraging communities to expand their mental health services (3).

THE COMMUNITY MENTAL HEALTH CENTERS ACT OF 1963 AND ITS CONSEQUENCES

Nevertheless, activists faced a daunting problem, namely, that responsibility for policy resided with 48 state governments. In the hope of altering intergovernmental relations and forging a national policy, a number of organizations created the Joint Commission of Mental Illness and Health. A private undertaking, the commission received congres-

sional endorsement with the passage of the Mental Health Study Act of 1955, which authorized the Public Health Service to provide federal grants. After nearly six years of work and the publication of nine monographs, the commission issued its final report, Action for Mental Health. The report presented a large number of recommendations and a plea for a dramatic increase in federal funding (3, 4).

Although President John F. Kennedy was sympathetic to Action for Mental Health, he faced conflicting pressures. On one side were those pushing for legislation dealing with mental retardation; on the other were key congressional figures determined to secure legislation dealing with mental health. Kennedy sidestepped the issue by appointing an interagency task force on mental health to recommend legislation. Because its members were not especially knowledgeable about the subject, they relied on Felix and the NIMH to guide their deliberations. Felix adroitly used his position to further his agenda. Neither he nor his staff favored the recommendations of the Joint Commission. Whereas the commission had emphasized the care and treatment of persons with severe disorders, the NIMH favored a more comprehensive policy focusing on "the improvement of the mental health of the people of the country through a continuum of services, not just upon the treatment and rehabilitative aspects of these programs." Radical, not incremental, change was required. Felix and his colleagues therefore recommended the adoption of a comprehensive community program that would make it possible "for the mental hospital as it is now known to disappear from the scene within the next twenty-five years." Its place would be taken by a new institution – a community mental health center (CMHC) – that would offer comprehensive services to all Americans (5-7). Felix's views prevailed, and in 1963 Congress enacted the Community Mental Health Centers Act, which provided a three-year authorization of $150 million for construction. The act envisaged the creation of 2,000 centers by 1980. Two years later Congress enacted legislation that offered financial support for staffing (8, 9).

The passage of this legislation, however, represented the victory of ideology over reality. The functions of a CMHC remained vague and undefined. Equally important, a community mental health program was based on certain assumptions: that patients had a home in the community; that a sympathetic family would assume responsibility for the care of a released patient; that the organization of the household would not impede rehabilitation; and that the patient's presence would not cause undue hardship

for other family members. In 1960, however, 48% of the hospitalized population was unmarried, 12% widowed, and 13% either divorced or separated. The assumption that patients would be able to reside in the community with their families while undergoing rehabilitation was hardly supported by such data. Indeed, a community-based policy had to incorporate supported services that included, but were not limited to, income support, occupation and housing. Such data (which were obviously known to Felix and others who set the agenda and developed a rationale for the CMHC concept) were barely considered during the political and legislative deliberations between 1961 and 1963, even though they were crucial to the implementation of the new policy departure (10-13). Nor was attention given to the sharp increase required in the numbers of psychiatrists needed to staff 2,000 centers. Indeed, there would have had to have been a dramatic reduction in the supply of general practitioners and specialists, thereby exacerbating other health problems (3).

Moreover, the legislation and the subsequent regulations governing CMHCs provided no linkages with state hospitals. State authorities, who traditionally had administrative responsibilities for overseeing policy implementation, were also bypassed in favor of a federal-local partnership. This reflected the prevailing belief that states had failed in their social welfare responsibilities, and that the federal government, in partnership with their local counterparts, was more enlightened and better suited to oversee social policy (3).

Aside from the consequences for intergovernmental relationships, the act of 1963 was designed to create a novel institution that would reshape mental health policy. Yet what is especially striking in retrospect was the ill-defined nature and functions of CMHCs. The potential clients of centers were generally described in global and protean terminology, and they included the non-mentally ill as well as persons with severe and persistent mental disorders. More important, the legislation did not spell out with any degree of precision the administrative relationships between such centers and traditional mental hospitals, nor was serious consideration given to the ways in which centers would assume the caring roles of existing mental hospitals. That mental hospitals had major shortcomings was indisputable. Yet at the very minimum they were the only institutions that were prepared to provide the basic care required by persons whose condition generally rendered them dependent upon others. How would centers assure minimum levels of care (food, clothing, shelter) as well as support mechanisms that would enable

such individuals to cope with their environment? Indeed, the legislation dealt with the construction of physical structures, but was largely silent on their basic functions. Nor did the law deal with the problem of adequate staffing levels (3).

The creation of CMHCs came during a decade when mental health rhetoric and ideology paralleled newly enacted federal social and economic problems designed to eliminate poverty. Both grew out of the belief that the origins of most social problems could be found in a deficient environment. Community psychiatry was the term that perhaps best defined some of the distinguishing characteristics of these years. It drew its inspiration from a variety of sources. Faith in the redemptive qualities of modern psychiatry was fused with demands for social justice, for an end to structural barriers that impeded individuals from realizing their full potential, and for the realignment of mental health services at the community level. Community psychiatry was nothing less than a psychiatric revolution that would saturate a given geographical area with services that would provide both preventive and therapeutic services for all families. Nowhere were these goals better presented than in Gerald Caplan's Principles of Preventive Psychiatry (14).

Reality, of course, rarely corresponds with sought-after ideals. Human beings have an almost limitless capacity to conceptualize change. Their ability to ensure that there is a direct relationship between policy transformation and eventual outcome is more circumscribed and tenuous. The developments that followed passage of the CMHC Act of 1963 offers compelling proof of this generalization.

The goal of mental health policy in the 1960s was the expansion of community mental health services and the eventual disappearance of mental hospitals. To be sure, the increase in the numbers of centers was less than anticipated because of the fiscal pressures caused by the Vietnam War. Yet CMHCs did not replace traditional mental hospitals, nor did they focus on individuals with the severe and persistent disorders. Many centers devoted much of their attention and many of their resources to the treatment of individuals experiencing less serious psychological disturbances or problems in living. Unlike mental hospitals, they rarely provided an integrated system of care and treatment. Relatively few were linked with mental hospitals. Since CMHCs had considerable autonomy and freedom from state regulations, they focused on a new set of clients who better fit the orientations of mental health managers and professionals trained in psychodynamic and preventive orientations. The treatment of choice at

most centers was individual psychotherapy, an intervention especially adapted to a middle-class, educated clientele without severe disorders and one congenial to the professional staff composed largely of social workers and clinical psychologists. In effect, CMHCs broadened the clientele of the mental health system, but tended to ignore the needs of persons with severe mental disorders. Most CMHCs, Donald C. Langsley (president of the American Psychiatric Association) charged in 1980, were offering "preventive services that have not yet been proven successful" and "counseling and crisis intervention for predictable problems of living." "A critical consequence of these events," he added, "has been the wholesale neglect of the mentally ill, especially the chronic patient and the deinstitutionalized" (15, 16).

THE PARADOX OF DEINSTITUTIONALIZATION

Faith in preventive efforts and community mental health programs reinforced the belief that institutionalization would eventually become a relic of the past. To be sure, mental hospital populations, which peaked in the mid-1950s, began an uneven decline. Between 1955 and 1965 state hospital populations fell by only 15%. During the following decade, the decline was 60%, although rates varied from state to state. There was a widespread belief that CMHCs played a role in what subsequently became known as deinstitutionalization (17).

In some respects, however, the term "deinstitutionalization" is somewhat of a misnomer. Indeed, the first wave of deinstitutionalization actually involved a lateral transfer of predominantly aged persons from state mental hospitals to long-term nursing facilities because states were motivated to benefit from a windfall of new federal dollars. Between 1900 and 1960 state hospitals were serving in part as old age homes. The enactment of Medicaid in 1965 encouraged the construction of nursing home beds because it provided a payment source for patients transferred from state mental hospitals or admitted to nursing homes and general hospitals. Although states were responsible for the full costs of patients in their public mental hospitals, they could transfer patients to other facilities and have the federal government assume from half to three-quarters of the cost, depending on the state's economic status. This incentive encouraged a mass transinstitutionalization of long-term patients with dementia who had been previously housed in public mental hospitals for lack of other institutional alternatives. In 1963 nursing homes cared for nearly 220,000

individuals with mental disorders, of whom 188,000 were 65 or older. Six years later the comparable numbers were 427,000 and 368,000 (18-21). Within a short time, according to a 1977 study by the General Accounting Office, Medicaid had become "one of the largest single purchasers of mental health care and the principal federal program funding the long-term care of the mentally disabled." It was also the most significant "federally sponsored program affecting deinstitutionalization" (22). The shift from mental hospital to nursing facility care, therefore, was a development driven by a desire to promote the use of federal resources rather than by a desire to improve the lot of elderly persons and others with a severe and persistent mental disorder.

A second wave of deinstitutionalization began in the early 1970s that included new cohorts of persons with mental disorders coming to public notice for the first time. Between 1946 and 1960 more than 59 million births were recorded. The disproportionately large size of this age cohort meant that the number of persons (most of whom were young) at risk to develop a severe mental disorder was very high. This cohort was also highly mobile and often had a dual diagnosis of a mental disorder and substance abuse. The availability of a series of federal entitlement programs – including Social Security Disability Insurance (SSDI), Supplementary Security Income for the Aged, the Disabled, and the Blind (SSI), Medicaid, Section 8 housing, and food stamps – encouraged states to make admissions to mental hospitals more difficult, if only because resources for persons with severe mental disorders in the community were available (23).

Treatment in the community for clients with multiple needs, as compared with mental hospital care, posed severe challenges. In the community (and particularly in large urban centers) clients were widely dispersed and their successful management depended on bringing together needed services administered by a variety of bureaucracies, each with their own culture, priorities and preferred client populations. Although there were sporadic and occasionally successful efforts to integrate these services (psychiatric care and treatment, social services, housing, social support) in meaningful ways, the results in most areas were dismal. These new patients were treated during short inpatient stays in general hospitals and in other outpatient settings; they had to make do with whatever services they could garner.

The decentralization of services and the lack of integration made it extraordinarily difficult to deal with persons with severe disorders in the community, and

many became part of the street culture where the use of alcohol and drugs was common. Individuals with a dual diagnosis of a serious mental disorder and substance abuse presented such serious problems that many mental health professionals were reluctant to deal with them despite their growing numbers. With the decline in institutional care and the greater reliance on pharmaceuticals, care for most patients occurred in ambulatory settings with a strong focus on avoiding inpatient admissions. Even when admitted, patients stayed for six to eight days, largely to stabilize symptoms. Many severely ill patients who were no longer protected by the custodial services of mental hospitals – housing, nutrition, daily activities, supervision – have been more likely to get into difficulty, use drugs and alcohol, become homeless, and engage in disorderly conduct and petty crime. These patients are now arrested and jailed. A report from the Treatment Advocacy Center found that there were ten times more people with serious mental illnesses in state prisons (207,000) and county jails (149,000) than there are in state mental hospitals (35,000) (24, 25). Efforts to integrate services at the community level and develop more effective mental health authorities have had but limited success (26). To be sure, collaboration between the mental health and prison systems was possible, but often different perspectives, values, and cultures placed formidable barriers in the way of cooperation.

In the last third of the 20th century, states pursued a policy of reducing their mental hospital populations by placing barriers in the way of new admissions and only as a last resort. This policy, in conjunction with the vast expansion in the clientele and diagnoses (as exemplified in the third and subsequent editions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders since 1980), shifts in public attitudes and perceptions, changing treatment strategies, and social and economic factors, led to the emergence of a confusing array of organized and unorganized settings for the treatment of persons with mental illnesses. State mental agencies, which in theory were responsible for administering the mental health system, found themselves faced with declining resources and an increasing inability to influence policy. Multiple sources of funding from a variety of federal programs administered by independent agencies made it difficult to develop and implement comprehensive, integrated and effective community-based services. Many of the components of community mental health care – income support, housing, social support networks – were designed for other populations and did not fit the needs of persons with severe and cyclic persistent mental illnesses.

When the General Accounting Office prepared a comprehensive report for Congress in 1977, it laid bare the problems of a disorganized and uncoordinated mental health system. Although endorsing deinstitutionalization, the report was extraordinarily critical of the manner in which it was implemented. Responsibility for the care, support, and treatment for persons with serious disorders was "diffused among several agencies and levels of government," and there was little or no coordination between the 135 federal programs administered by 11 major agencies and departments (22).

Upon taking office in early 1977, Jimmy Carter created a presidential commission to investigate the mental health system and present recommendations. After public hearings and months of deliberations, the commission presented more than 100 recommendations in the spring of 1978 that affected not only intergovernmental relations, but public and private agencies and such programs as Medicare and Medicaid. The diversity of its recommendations, however, could not easily be translated into legislation (27).

For more than two years the administration and Congress struggled in an effort to draft appropriate legislation. The problem was the absence of any consensus on mental health policy. Deinstitutionalization – whatever its meaning – was coming under widespread criticism. In October 1980, Congress finally enacted and Carter signed into law the Mental Health Systems Act. While in theory assigning the highest priority to individuals with long-term mental disorders, the legislation also recognized the claims of other groups whose needs were quite different, including children and adolescents, the elderly, rural residents, and victims of rape. The absence of resources and vague generalizations about required services, however, raised doubts about the legislation's effectiveness. Moreover, claims about the prevention of mental illnesses and promotion of mental health, reflected ideology and were little more than attractive slogans that had little or no basis in empirical data (28-31).

No sooner had the Mental Health Systems Act become law when its provisions were rendered moot. The inauguration of Ronald Reagan as President in January 1981 led to an immediate reversal of policy. In the summer of 1981 the passage of the Omnibus Budget Reconciliation Act provided block grants to states for mental health and substance abuse (at reduced levels). With but few exceptions, the Mental Health Systems and CMHC Acts were

repealed, thus – at least in theory – diminishing the direct role of the federal government in mental health (32).

Serendipity, however, often plays an unrecognized role in human affairs. The final report of Carter's President's Commission called for the establishment of a national priority and a national plan to meet the needs of persons with long-term mental illnesses. Completed at the end of 1980, the plan laid out a blueprint for future action that was designed to mitigate the actions of the Reagan administration to limit if not reduce the social welfare functions of the national government. The National Plan, by contrast, offered recommendations to change both statutes and regulations governing important mainstream health and social welfare programs, including Medicare, Medicaid and the disability programs of Social Security Administration which affected people with severe and persistent mental disorders. By the 1990s Medicare and Medicaid eclipsed state categorical dollars as a source of mental health funding. While the new federalism restored some of the lost state authority in mental health services policy, the federal government actually picked up more of the bill (30, 33, 34).

Although a variety of federal programs mitigated the negative impact of the Reagan administration's policies, the mental health system remained fragmented. Federal agencies in charge of entitlement programs were separated by bureaucratic walls from the Department of Health and Human Services and other departments with some influence on the lives of individuals with a serious mental disorder, including the Department of Housing and Urban Development and the Departments of Labor and Education. A range of new social problems involving people with mental illnesses (homelessness, substance abuse, HIV/AIDS) created new pressures. Medicaid and Medicare may have improved mental health benefits, but these benefits had more limitations than those of general health benefits.

In the 1990s the gap between research and practice led to the publication of the Surgeon General's Mental Health. Its recommendations were general in scope: the necessity of building the science base; the need to overcome stigma; the importance of improving public awareness of effective treatments; the need to tailor; the need for an adequate supply of mental health services and providers; the importance of delivering state-of-the-art treatments; the need to tailor treatment to age, gender, race and culture; and the importance of facilitating entry into treatment as well as reducing barriers to treatment (35).

In 2003 George W. Bush created the President's New Freedom Commission on Mental Health. Its mandate called for a "transformation" of the nation's mental health system, which was "fragmented, disconnected and often inadequate, frustrating the opportunity for recovery." It made the concept of recovery central. Yet its recommendations lacked specificity, nor were they linked to federal, state or local mental health policies (36).

The New Freedom Commission report emphasized the concept of "recovery." Yet this concept was unclear, confusing and even contradictory (37). Much of its appeal lay in its optimistic rhetoric. Indeed, the report went beyond the scientific evidence base in its advocacy of prevention and its focus on recovery. Unfortunately, our understanding of the major mental illnesses is limited and at present there is no evidence-based preventive strategy. Moreover, rhetorical claims about the effectiveness of clinical interventions have often concealed underlying problems and contradictions (38-40).

Persons with a serious mental disorder are not a homogeneous population. Some have only one episode and then return to their previous functioning. Others recover only after years of disability. Focusing solely on cure or recovery runs the risk of abandoning people whose serious illness leads to prolonged disability. The concept of recovery, two psychiatrists have noted, is a "concept in search of research" (41). If it means participating to the fullest extent possible in the community despite one's impairments, there is considerable evidence demonstrating that with reasonable treatment and appropriate psychosocial and supportive services many of the secondary disabilities that often occur with severe mental illnesses can be prevented or minimized (42).

Yet basic psychiatric care remains deficient, especially for those with severe and disabling disorders. Individuals with such disorders served by the public mental health systems die, on average, 25 years earlier than the general population due to treatable medical conditions (43). Too many persons with mental illnesses are incarcerated rather than in treatment; care remains fragmented and uncoordinated; and people with these disabilities develop secondary problems that are preventable. Translation of much of what we have learned to clinical practice has been exceedingly slow. There is an unwillingness to recognize how little we really know and too many claims and treatments cannot be sustained by any reliable evidence. The power of pharmaceutical companies and its corruptions remains pervasive, and many psychiatric researchers have compromised ties with the industry (44).

CONCLUSION

What can we learn from knowledge of the past? At the very least, history suggests that there is a price to be paid for implementing ideology ungrounded in empirical reality and for making exaggerated rhetorical claims. The sustained attack on a century-old institutional policy, for example, was based on a superficial if not misreading of the history of mental health policy in the United States and was advanced as part of a campaign to justify the new community-oriented policy that subsequently became known as deinstitutionalization. The ideology of community mental health and the facile assumption that residence in the community would promote adjustment and integration was illusory and did not take into account the extent of social isolation, exposure to victimization, and criminalization of persons with mental disorders. The assumption that CMHCs would assume responsibility for aftercare and rehabilitation of persons discharged or not admitted to mental hospitals proved erroneous. The absence of mechanisms of control and accountability permitted CMHCs to focus on new populations of more amenable and attractive clients with far less serious disorders. Nor does the recent move to enroll persons with severe mental disorders in managed care offer assurances that the varied needs of this group will be met. Preliminary evidence suggests that a "democratization" of services reduces the intensity of services for patients with more profound disabilities and needs (45).

Equally notable are the roles played by rhetoric and ideology in the development of mental health policy and a view of the past that bore little relationship to reality. To dismiss rhetoric and ideology as simply forms of public posturing is to ignore their consequences. Rhetoric and ideology shape agendas and debates; they create expectations that in turn mold policies; and they inform the socialization, training and education of those in professional occupations. The concept of community care and treatment and the corresponding attack on institutional care, all of which played significant policy roles since 1945, were not inherently defective. But states, communities and policy advocates ignored the need for social support systems, housing, occupation and income for those whose illness led to disability. At the same time optimistic claims about the prevention of mental disorders – which had little or no empirical evidence – helped to expand the clientele of the mental health system and overlook those most in need of care and treatment.

Does the evolution of mental health policy in the United States have lessons for Israel? To be sure, the "lessons" of history are generally ambiguous and conflicting. Yet certain broad themes are evident. Will the expansion of community mental health services in Israel expand the population seeking such services and thus deflect attention from those most in need, namely, persons with serious and persistent mental disorders? The transfer of responsibility for inpatient and ambulatory services to organizations providing general health care also has the potential to magnify this risk. Will sufficient funding be provided to support community rehabilitative services for persons with serious and persistent mental disorders? Will the lofty goals in the Rehabilitation of Persons with Mental Disabilities Law (BMD) in 2000 be implemented in practice? It is, after all, relatively easy to articulate goals, yet avoid the far more difficult tasks of providing realistic means of implementation. Certainly the American experiences with implementing the lofty ideals of the CMHC program illustrates this dilemma; the outcome had little to do with the original goals. Aside from rhetoric, are mechanisms in place to evaluate in a realistic manner the efficacy of reforms?

The history of mental health policy in the United States provides a fascinating if largely ignored case study of the interaction of political structure and ideology. In the 19th century a faith in institutionalization led to the creation of a vast system of public mental hospitals that at their peak held more than half a million patients. Yet an incremental policymaking process and intergovernmental rivalries led to a series of unanticipated consequences. By the early 20th century mental hospitals were providing care for large numbers of elderly persons at a time when other alternatives were lacking. A half century later dissatisfaction with the existing state of affairs led to demands that an allegedly obsolete and archaic institutional system be replaced by a new community-based policy. Each of these stages was shaped by intergovernmental rivalries that maximized efforts to shift costs to different governmental levels and ideological claims that bore little relationship to reality. Moreover, the growth of a system of public welfare that included a myriad of entitlement programs to deal with sickness and dependency had the inadvertent effect of diminishing the central policy focus on persons with severe and persistent mental disorders. As long-term institutionalization diminished and was replaced by a series of public programs that focused on different populations, those with severe and persistent mental disorders were faced with a system of services

ill-suited to their complex needs. Americans at the beginning of the 21st century still faced the problem of shaping a policy that meets the needs of a group whose severe mental disorders creates dependency.

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Recovering Citizenship

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ABSTRACT

Recovery as a process through which people reclaim their lives even while continuing to experience symptoms of mental illness has at times been misunderstood or misinterpreted, including being used as an excuse for cutting needed services and supports in the guise of allowing people to pursue their own personal "recovery journeys." In delivering a message of hope to individuals and fostering initiatives to counter the debilitating impact of clinical pessimism, recovery literature has also, at times, paid less attention to the material, social, cultural, political and economic contexts in which people pursue recovery. The importance of these contexts are implied in a 1961 American Report on Mental Illness and Health that argued that people with mental illnesses should be able to live their lives "in the normal manner" in their home communities. We argue for a disability model that provides people with necessary supports and services to make individual recovery possible for persons with prolonged mental illnesses. Another model that has emerged over the past decade to counterbalance this overweening emphasis on the lone individual pursuing his or her recovery journey is citizenship. We discuss this concept and our research on it since the late 1990s. We then argue for "recovering citizenship" as a concept and metaphor to capture the individual recovery process within the context and goal of a life in the community that the citizenship framework supports.

"In the end, fame is nothing but a constellation
of all the misunderstandings that have gathered about
a new name"
- Rainer Maria Rilke (1)

From a historical perspective, it would seem that what Rilke came to understand about the nature of fame may, unfortunately, also be said about many of the major mental health policy directions taken since the birth of the discipline in the late 18th century. In this introduction, we mention only two examples of such persistent misunderstandings before turning to the current context, which offers numerous examples of its own. After attempting to clarify these more recent misunderstandings, we then argue for moving the field of psychiatry toward a new vision of citizenship that incorporates but also concretizes many of the admirable values and principles of the past that have yet to make their way fully and effectively into our practice. We end by offering some examples from our own program development efforts of what such a vision begins to look like in practice.

At a time when persons with mental illnesses were locked in chains and filth and either abandoned or abused, Pinel envisioned psychiatry to be a humane science that rendered social therapies with "thoughtful tenderness" to "unfortunate" people who were suffering from "a vivid sensitivity and from psychological qualities that we value highly" (2). He inaugurated the era of "moral treatment" from which Dorothea Dix herself then benefitted some 30 years later; as a result, she dedicated herself tirelessly in her later years to ensuring that people of all social classes would have access to the same kind of safe and family-like setting she had experienced during her own episodes of acute distress. What resulted, however, was over 100 years of institutionalization and largely custodial care from which we as a field are still recovering. What began as "moral treatment" somehow, somewhere along the road became something very different.

With the aging and overcrowding of state mental hospitals breaking the fiscal backs of budget-conscious governors in the 1950s, the U.S. (and many other countries) then turned their attention toward the promise of "deinstitutionalization." In the words of Eisenhower's Joint Commission on Mental Illness and Health, with the depopulation of state hospitals it then became "the objective of modern treatment of persons with major mental illness to enable the patient to maintain himself in the community in the normal manner" (3). At the time of

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this noble pronouncement, however, there were only "nine halfway houses, fewer than two dozen partial hospitals, and eight rehabilitation centers" in the entire country (4, 5). Given that Congress failed to allocate any significant, new funds for community-based services to replace those provided (or not) in the hospital, it is not surprising in retrospect that many of those discharged from the state hospital system were trans-institutionalized in nursing homes or board and care homes, and that many others have ended up homeless and/or in jails and prisons (5). As a result, the objective of enabling people to live in the community "in the normal manner" became re-interpreted in practice as "maintaining" people outside of hospitals (6).

Such was the conclusion of the most recent federal commission to review the status of mental health care in the U.S. The report of this commission was entitled Achieving the Promise: Transforming Mental Health Care in America (6), and the promise to which it referred in its title was that of the "life in the community" first promised in 1961. The new policy direction laid out in this report is that of transforming mental health care to a "recovery" orientation as yet another attempt to fulfill that promise, and it is with the misunderstandings presently amassing around this term to which we now turn. We do so in the hopes of not repeating the mistakes of the past, and argue for promoting the new concept of "citizenship" (7) as one way of safeguarding and enriching a vision of recovery that, at this point, appears vulnerable to suffering a fate similar to that of moral treatment and deinstitutionalization.

RECOVERY AND RECOVERY-ORIENTED CARE

Almost since its inception (8), the concept of being "in recovery" with a serious mental illness (9) – also described as recovery as a process (10), "personal recovery" (11), or a "consumer" model of recovery (12) – has been the object of considerable confusion and concern. First, it has been conflated with recovery from a serious mental illness, also described as recovery as an outcome, "clinical recovery" (11), or a "scientific" model of recovery (12). While the nature of the relationship between these two forms of recovery has yet to be decided (13, 14), we suggest that as concepts they are conceptually distinct, referring to two different phenomena.

Recovery from a serious mental illness may seem to be a straightforward concept, as it has similar meaning to recovery from other (primarily acute) health conditions, but it has been controversial nonetheless. It refers to a person getting to a point where he or she no longer

has any signs, symptoms or sequelae of mental illness. What has been controversial is that this appears to be a phenomenon that occurs much more frequently than has been thought historically (15). Numerous longitudinal studies conducted over the last half-century have consistently found that between 47 and 67% of persons diagnosed with schizophrenia will experience significant improvements in their condition over time, many recovering fully (16-18). This consistent body of research is just now beginning to change a century-old assumption that once you have a serious mental illness you would have it for the remainder of your life. Were this the only meaning of recovery in relation to serious mental illness, it alone would pose many challenges for changing practice, as the system of care that we have inherited from our predecessors was based on "reducing symptoms and accepting long-term disability" (6). If disability is not necessarily associated with serious mental illness, then what causes it and how can it be prevented? The current focus on early intervention represents one attempt to explore and promote this possibility.

This is not, however, the only meaning of recovery. There also is recovery as a process. One way to define this second meaning of recovery would be to suggest that the person in recovery is on the way to, but has yet to achieve, recovery as an outcome. Doing so, though, raises many unanswerable questions, such as can a person still be considered to be in recovery while experiencing a relapse or setback, or is there ever a time when a person would not be considered to be in recovery. If that question cannot be answered, then, as Roe and colleagues have suggested, the term becomes meaningless (14).

We suggest that a more useful way to distinguish between the two meanings may be to point out that the second meaning of recovery, i.e., recovery as a process, only makes sense in the absence of the first meaning of recovery, i.e., recovery as an outcome. You do not need to be in recovery if you have already recovered. Being in recovery only becomes a relevant idea for those persons who have persistent, unremitting conditions. For these persons, being in recovery refers to living one's life as best and fully as one can in the face of a mental illness that won't go away (i.e., is not cured by current interventions). It is for this reason that we have insisted that the concept of being in recovery is most relevant to, and most urgently needed by, precisely those persons who are the most affected by mental illness, those persons whose practitioners continue to insist are "too sick" to benefit from recovery-oriented practice (19).

It is perhaps in the differences between these two ways of understanding being in recovery that many of the current misunderstandings surrounding recovery can be located. One of the most pernicious misunderstandings, or distortions, of this sense of recovery has arisen as a politically expedient cover for cutting funding for mental health services (20). If so many people recover, so this line of reasoning goes, then we can spend less for services and supports. And if they do not recover, under this scenario, it is because they are not working "hard enough" on their own recovery (21). Such an instance of "blaming the victim" appears to have been supported, unintentionally, by statements about recovery being "the person's responsibility" or a "unique, personal journey." Rather than empowering persons with serious mental illnesses to reclaim their lives – as was the intent behind such statements – they have been taken, or at least used, by neoliberal policy makers to justify cut backs on care, arguing that to the degree to which recovery is a personal responsibility it becomes less of a societal one (20).

Such a misinterpretation might be less harmful were it only made about persons who have recovered from serious mental illnesses; persons, that is, who no longer require intensive psychiatric care. But to make this argument about persons in recovery, persons who are doing their best to live their lives in the face of a serious mental illness, belies a serious misunderstanding of the nature of "personal recovery." As we noted above, being in recovery is not best understood as being on the way to or approaching recovery as an outcome; to use a marketing term, it is not recovery "lite." Rather, being in recovery was introduced initially, and we suggest is best understood, on the basis of a disability model. Consistent with the inclusion of mental illness as a disability under the Americans with Disabilities Act, Pat Deegan (22) drew inspiration from, and parallels between recovery and, the Independent Living Movement among persons with physical disabilities. She envisioned "recovery" as a way for persons with serious mental illnesses to take back control of their own lives even while they remained disabled.

No rationale or justification for cutting funds for mental health services or supports can be derived from such a disability model. A disability model draws attention to person-environment interactions as the locus where disability is situated, calling for practitioners and society at large to craft environmental modifications, such as curbs in sidewalks, that enable persons with particular needs to have full access to community life. As a result, one of the advantages of adopting a disability model is that it argues for removing the arbitrary funding restrictions currently placed on community-based supports in mental health, such as job coaches. It makes no more sense to take a job coach away from a person with a serious mental illness after a few months than it does to take a wheelchair away from a person with a mobility impairment or a service dog from a person with a visual impairment. Persons with what have been described as "psychiatric disabilities," persons who are "in recovery" with a serious mental illness, may still have profound needs for services and supports in order to live the best lives they can – just like people with other forms of disability to whom our societies have pledged the resources, opportunities and supports needed to make it possible for them to have as independent lives as possible.

Perhaps recovery advocates have been mistaken to emphasize that recovery is a unique and personal journey for which the person bears a majority of the responsibility. But these statements were made within the context of understanding being in recovery to be a long-term process of learning how to live one's day-to-day life with an on-going condition that one neither asked for nor earned as punishment for an undisclosed sin. People in the position of having no choice but to do so (i.e., to live with a disability) warrant our compassion and support – social, emotional, instrumental and material – rather than our blame, shame or neglect (23).

Many of the concerns expressed about (23), and abuses of (21), the term recovery are best addressed by referring back to this understanding of being in recovery. For example, one of the most common concerns expressed about recovery by practitioners and policy makers is that of risk (23). The concern is that encouraging persons with serious mental illnesses to articulate their aspirations, set their own goals, and make their own decisions will increase the degree to which they will make bad choices and put either themselves or others at risk of harm. On what is this concern based? Would such a concern be expressed about persons with any other type of disability? And what makes practitioners or policy makers think that they know better how to live with a disability they have never experienced than people who are living with that disability every day? In the end, persons with mental illnesses living outside of institutional settings will make their own decisions anyway; what harm could be caused by acknowledging this fact openly and working collaboratively with them to assist them in making the best decisions that they can? People in recovery are no more aggressive, pose no more risk, than people with, or without, other forms of disability (24). Having a mental illness does not make a person "bad."

The flip side of confusing mental illness with risk has been confusing recovery with being mature or becoming a "better" person (25). While some people in recovery do talk about having become a more compassionate and/or open person by virtue of their suffering and overcoming of adversity, we should not (mis)take this admirable byproduct of the process to be its aim. Describing someone as being in recovery should be taken to mean that this person is striving to live his or her life as fully as possible in the face of a serious mental illness, it should not be (mis)taken to be expressing a value judgment about this person's moral worth or degree of social-emotional maturity. There is just as much diversity in terms of moral worth and social-emotional maturity among persons in recovery as there is among persons who have never experienced a serious mental illness, including mental health practitioners. Given the history of the field, no one should equate psychiatry with moral philosophy. Similarly, we should neither expect nor demand that persons with serious mental illnesses become "better" people in order to be viewed as being in recovery. They have their hands full, first dealing with the curve ball thrown to them by life and then in figuring out how to live their lives in the face of an illness that will not go away. Should they become more compassionate and open people as a result of doing so, all the better for them. We have no right, however, to mandate that as an expectation or stipulate that as an aspect of recovery per se.

As we can see in the examples above, many of the misunderstandings that have amassed around the concept of recovery have focused narrowly on the individual person and his or her attributes. Has he recovered, is she likely to hurt someone, has he become a better person, and, perhaps most importantly, is she taking responsibility for taking up her own unique journey? Less attention has been paid to the material, social, cultural, political and economic environment in which recovery can be impeded or nurtured, or the nature of the interpersonal relationships needed to support persons in their recovery, whether with mental health practitioners or with family and friends. Over the last decade or so, another concept has begun to develop around the globe to counterbalance this over-emphasis on the individual nature of recovery and to begin to articulate the nature of the responsibility that the community bears, not only in promoting recovery per se but in affording persons with serious mental illness full "citizenship" as a foundation for recovery (rather than as its eventual reward; 26). It is to that concept that we now turn.

CITIZENSHIP AND CITIZENSHIP-ORIENTED CARE

We have defined citizenship as the person's strong connection to the 5 Rs of the rights, responsibilities, roles, resources and relationships that a democratic society makes available to its members through public and social institutions, the "associational life" of voluntary organizations such as churches and neighborhood organizations, and social networks and everyday social interactions (7, 27). Further, a sense of belonging in one's community and society both supports and is supported by a strong connection to the 5 Rs. This sense of belonging must be validated by others' recognition of one's valued membership in society (28, 29).

Two main paths to citizenship are available for excluded persons and groups. One involves individual efforts and supports to gain access to full citizenship; the other involves society's responsibility to open up access to citizenship, including but not limited to legal citizenship for previously excluded or marginalized groups (30). As governments and societies erect barriers to this path to citizenship, social activism of excluded persons and their supporters, and resulting social conflict, is often required to clear the way.

Citizenship has gained traction in the mental health field over the past decade but still is a relatively new and less widely known concept than recovery. In addition, ours is a particular approach to citizenship that emerged from mental health practice in the later 1990s. Thus it will be useful to review some key marker points for our efforts to begin to realize this vision of citizenship in practice. We briefly discuss five: (1) initial development of citizenship theory in mental health outreach (homeless outreach); (2) a citizenship-based community coalition; (3) an individual citizenship intervention; (4) development of an instrument to measure citizenship at the individual level; and (5) in-progress efforts to develop and test citizenship-oriented care at a large community mental health center.

1. Homeless outreach and citizenship. The notion of citizenship as a way of thinking about full membership in society for people with mental illnesses was, in retrospect, a logical outgrowth of a sociological understanding of homeless outreach and of the limitations, as well as the strengths, of that work. Homeless outreach, based in part on the Assertive Community Treatment (ACT) model, was a response to a new phase of homelessness in the U.S. starting in the late 1970s and early 1980s, characterized broadly by a massive increase in single persons, largely male, living on the streets who were poorer and more likely to have serious mental illnesses than was the case

in the "Skid Row" era of homelessness that preceded it (31). In homeless outreach, clinicians, case managers, and others leave their offices to find, make contact, and build trust with people who, in many cases, have dropped out of treatment and shun mental health care. Building on people's strengths and addressing their stated needs first whenever possible, outreach teams help their clients gain access to income through entitlement programs or employment, primary and dental care, and other services and supports with the goal, eventually, of persuading them to accept treatment and helping them find housing (7, 32).

Our ethnographic research on outreach work (7) led us to conceptualize the encounters of people who were homeless and outreach workers as transactions and negotiations at the physical, socioeconomic and psychological borders of society and as involving the instrumental domain of practical services and supports and the expressive domain of relationships and identity. The last – identity – was potentially troublesome for outreach clients, as they contemplated an exit from the highly stigmatized category of homelessness to what might be substandard housing and social lives defined and arranged around their status as patients receiving public mental health care (7). We found, during the early stages of housing clients, in fact, that some people felt so isolated, out of place, and disconnected in their apartments that they began to consider a return to living on the streets. There, they had friends and the status of being able to survive homelessness. What seemed to be missing was support for having friends and a positive status, along with many other aspects of full citizenship in mainstream society, once housed and engaged in care (30).

2. A citizenship-based community coalition. The first citizenship intervention – Citizens – was an attempt to put the community- and society-wide path to citizenship into practice. Citizens was a community coalition – a diverse group of people working together to address health and social problems with socioeconomic and political, rather than personal, roots (33) – composed of people who were or had been homeless, mental health providers, and community members who were not homeless or directly connected to mental health or other service systems. Among its objectives were to educate the public about the needs of people who were homeless and the contributions they could make to their home communities, and to "seed" the citizenship idea in local mental health care and social service systems. This, in turn, meant seeding the idea of the collaborations of the very groups of which the project was composed (30).

Citizens made its mark in its community education objectives by developing a book of interviews with people who were or had been homeless that chronicled their successes and struggles in making an exit from homelessness (34). Citizens also began to establish its presence in local service and care systems by creating the Leadership Project (nicknamed "Representation of the Governed"), which trained people who were or had been homeless to sit on the boards of agencies and action groups of local government and a statewide advocacy organization. The project was largely successful for students-interns and for board members, although it lacked the evaluation resources and time to measure its impact on agency policies and services (35). Citizens made only modest inroads into community change, but helped to set the stage for current community organizing that we discuss below.

3. Criminal justice and an individual path to citizenship: The Citizens Project. The opportunity to support individual's citizenship trajectories more holistically than the relatively narrow Leadership Project came about through work with the jail diversion program of the mental health center with which we are affiliated. The project's director, Dr. Madelon Baranoski, found that she had bumped up against a ceiling in her work similar to the one we had bumped up against in homeless outreach work, providing multiple services and supports to clients but learning that we could not confer upon them the status of neighbors, community members and citizens (personal communication, 1998). Similarly, jail diversion, as Dr. Baranoski had learned, could rescue people, with their agreement, from the criminal justice system in exchange for their accepting mental health care, but in transferring them from one system to another, more benign one, it did nothing to help them establish "a life in the community," a core goal of community mental health care from its inception in the 1950s and 1960s (36).

The Citizens Project, designed by clinicians, peer staff, advocates and researchers for people (students) with mental illness and recent criminal charges ranging from petty to felonious, is an integrated four-component intervention. A citizenship course based on the 5 Rs of citizenship is taught by community members, mental health and social service experts, staff and peer mentors, and students. Following the course, students complete socially valued role projects – teaching police cadets, for example, to more successfully and humanistically approach people who are street homeless and have mental illnesses. Valued role projects demonstrate to citizenship students and other community members that people with mental illness

and criminal histories can make positive contributions to society. Peer mentors provide individual recovery and advocacy support to students throughout the 6-month project (37). "What's up?" is a group exercise that starts each twice a week class or valued role session. The exercise gives people an opportunity to talk about themselves and their lives in an "extra-clinical" setting – the project meets at a community soup kitchen – and manner – the topics of family and social relationships, housing status, personal and social goals, and responsibilities are encouraged and more frequently voiced, with group support and feedback, than mental health symptoms, drug use, and criminal justice issues. "What's up?" supports individual citizenship work while fostering creation of a supportive community of citizens within the project itself (29).

A randomized controlled trial comparing the citizenship intervention to usual care found that citizenship participants had significantly decreased drug and alcohol use, increased quality of life, and increased satisfaction with work for those employed. Arrests decreased in both groups (38, 39).

4. "Going to the source": Citizenship measure development. With a definition and key principles and with interventions that addressed both community responsibility for increasing access to full citizenship and supporting individual's citizenship aspirations, we turned to developing an empirical measure of citizenship. Wanting to reflect individual and collective citizenship in our process as well as our outcome, we hired and trained a co-researcher group of persons with lived experience of mental illness, and "went to the source" by conducting focus groups, followed by concept mapping sessions, with people with mental illnesses and others with or without significant life disruptions (40) of incarceration, military services overseas, serious medical illnesses, and combinations of these including mental illness. Our completed 46-item measure, distilled from almost 800 items, followed by use of concept mapping software with hierarchical cluster analysis, resulted in seven citizenship domains: personal responsibilities, government and infrastructure, caring for self and others, civil rights, legal rights, choices, and world stewardship, or "giving back." These domains, which generally map on well to the 5 Rs and "belonging," also, in effect, responded to an occasional critique of citizenship as being so predominantly a legal status that it was of little use in addressing the social inclusion and participation of people with mental illnesses. Our respondents, in fact, viewed citizenship broadly and deeply, including but reaching well beyond legal citizen-

ship (41). The measure has since been validated (42).

5. Citizenship-oriented care. With definition and principles, positive empirical research findings, and an individual measure in hand, a next logical step was to take citizenship to scale by making it available to more people than the 25 to 30 who could go through a citizens project in a year. One way to do this was to develop "citizenship-oriented care" for use in mental health centers and clinics. This step, though logical, seems to contradict a core tenet of our framework – that systems of care are not equipped to support people's valued community membership and participation and, in fact, undermine this goal by their hegemonic presence in the lives of many people with disabling psychiatric disorders, conferring only a "program citizenship" that not only is a poor substitute for, but seems to render nearly impossible the achievement of, full citizenship. Our tentative solution to this contradiction is borrowed directly from the notion of recovery-oriented care. If clinical care cannot confer personal recovery on its clients but can support and be consistent with recovery principles, then clinical care, likewise, cannot confer citizenship on its clients but can be supportive and consistent with their citizenship efforts and aspirations. In the citizenship case, however, greater access to community resources and help in weaving those supports into persons' lives is imperative (29), as is an understanding of the impact of discrimination and deprivation on this population.

Citizenship-oriented care at our local community health center and local community is in its early stages. Current projects include replication of the citizens project model in an outpatient program for young adults and in a state psychiatric hospital for forensic patients preparing to return to their home communities; citizenship-oriented care for an assertive community treatment (ACT) team; "financial health" interventions to support and enhance clients' coping with their finances and moving toward greater financial security (43); linking people to community resources and social networks through their interests and passions rather than generic community connections; and building relationships with neighborhood associations to support their community building efforts and their inclusion and support of persons with mental illness in their midst. These projects build on the "two path" citizenship approaches of individual support and community change. In addition, the collective work of the overarching project has brought to the fore the need to address systemic issues within and outside mental health systems of care including social and health inequities, racism, and other forms of systematic exclusion and barriers to "a life in the

community" for persons with mental illnesses. We are evaluating this work, using a multi-pilot project model guided by the overarching citizenship framework.

RECOVERING CITIZENSHIP

This article began with a discussion of two forms of recovery for persons with mental illnesses – clinical recovery, in which the person is cured or goes into temporary or permanent remission from mental illness, and recovery as a process of regaining purpose, meaning, and joy in life even if or even though the person continues to experience the symptoms of a mental illness. We wrote of multiple definitions, interpretations, understandings and misunderstandings, and unintended outcomes of the "recovery as process" movement. One of these was that, while emphasis on the individual nature of recovery was a necessary response to clinical pessimism and its impact on the client's sense of worth and life chances, it has also unintentionally led to a tendency, and was used by some as an excuse for, not paying enough attention to the material, social, cultural, political, and economic environments that support or undermine individual recovery. A counterbalancing approach, we suggested, is citizenship as a framework for the social inclusion and full participation in society of people with mental illnesses. We named our article "recovering citizenship" with three different meanings of the term in mind. We close with them here.

Recovering citizenship means personal (as opposed to clinical) recovery's replenishing of its roots in social justice and social advocacy vis à vis the psychiatric survivor and physical disability movements that were foundational to its emergence. Research on clinical recovery, although often invoked to illustrate personal recovery's different meaning and mission, also inspired with its findings that people with serious mental illnesses often "got better" in the traditional, medical and clinical, sense. Personal recovery, in part, transferred the hope these findings gave to the hope for and conviction that people could recover a full and meaningful life even without achieving a clinical cure or remission. As above, this emphasis, over time, partly crowded out attention to personal recovery as a social and political movement. It is time for a rebalancing in favor of social and economic equity and human rights for people with mental illnesses (44).

Recovering citizenship also suggests that individual recovery can be achieved through access to the 5 Rs and belonging, based on the logic that you don't have to wait to

recover in order to become a citizen. This logic emphasizes recovery's link with "do it now" psychiatric rehabilitation approaches such as supported housing (45) and supported employment (46). These practices, reversing decades-old applied theories of gradual improvement in the stability, but not the recovery, of persons with mental illness, argue that you do not have to wait to "get better" in order to have access to basic normative goods such as independent housing and a job. Given the proper supports, a gradual movement from quarter way to halfway to through quarter way housing can be replaced by immediate access to independent housing. Given the proper supports and training, sheltered workshops and trial employment with staff accompaniment can be replaced with immediate entry into competitive employment. While acknowledging that there may be exceptions to this approach – some people may benefit from short-term transitional housing and not everyone may be "ready" for employment – the "do it now" approach represents a sea change, and a welcome one, in psychosocial theory and practice, for which recovery can claim an influence. Recovering what should be available to and possible for people with mental illnesses, then, is part of recovering citizenship.

Finally, recovering citizenship means that while recovery is replenishing its social roots, it also reminds citizenship, with its emphasis on the person's rightful place in society, of the person's unique journey to citizenship and life as a citizen. This remind, in turn, leads to another – that citizenship lives on the cusp of tensions between individual and social paths toward it, and must strive to maintain that tension, with neither one forcing out the other. Our colleague Patty Benedict, Director of the ongoing Citizens Project, contends that modest progress in one's individual recovery prior to enrollment in the project is helpful, if not imperative, for success as a citizenship student (personal communication, 2007). Yet that said and in closing, citizenship calls for socioeconomic and political efforts and a reaching across boundaries of disability and other barriers, including poverty and racism, to help people with mental illness, and others, to recover their right to full and valued participation in society. It is this vision that we argue must provide a foundation and framework for clinical practice to be effective, rather than continuing to view these broader, community-level issues as someone else's problem (47).

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Improving Community Mental Health Services: The Need for a Paradigm Shift

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ABSTRACT

Background: It is now over half a century since community care was introduced in the wake of the closure of the old asylum system. This paper considers whether mental health services, regardless of location, can be genuinely effective and humane without a fundamental paradigm shift.

Data: A summary of research on the validity and effectiveness of current mental health treatment approaches is presented.

Limitations: The scope of the topic was too broad to facilitate a systematic review or meta-analyses, although reviews with more narrow foci are cited.

Conclusions: The move to community care failed to facilitate a more psychosocial, recovery-focused approach, instead exporting the medical model and its technologies, often accompanied by coercion, into a far broader domain than the hospital. There are, however, some encouraging signs that the long overdue paradigm shift may be getting closer.

Western psychiatry is increasingly reported to be in a state of crisis (1), with challenges that include a poor reputation among other medical disciplines (2), a perceived lack of scientific status (3), diminishing confidence in the reliability and validity of diagnostic classifications (4), and growing concerns around the safety and effectiveness of psychiatric medications (5). In this respect, a systematic review of 503 studies examining perceptions of psychiatry, psychiatrists, and psychiatric treatments and institutions found pervasive negative attitudes among the general public, medical students, the media, other healthcare professionals, and patients and family members (6). Indeed, the 2008-2011 Action Plan of the World Psychiatric Association was obliged to incorporate specific goals for enhancing the discipline's image (7).

What factors might contribute to making psychiatric healthcare so uniquely critiqued and polarizing compared to other medical disciplines? This article considers a specific aspect of provision – community care (CC) – and examines the influence of current paradigms in creating and maintaining these kinds of discontent. We suggest that fundamental changes are required in order to develop evidence-based services that are capable of responding to patients' needs in humane and effective ways, and outline examples of approaches that are equipped to institute the necessary paradigm shift in both academic theory and therapeutic practice.

A BRIEF HISTORY OF COMMUNITY CARE

Community care usually refers to the delivery of specialist support and treatment in domiciliary settings, and is primarily organized via services like outpatient clinics, supported housing, day services, and the assignment of community psychiatric nurses and social workers. In western countries, the shift from institutional to CC occurred with the widespread closure of the asylums in the 1950s and 60s, and represented one of the most substantial policy changes in the history of mental health services. The main rationales offered for CC at the time, and since, were increasing access to better care; improving social integration; and eradicating the institutionalization, abuse and neglect that characterized many of the old-fashioned hospitals. Others have argued, however, that a major impetus was simply to save money (8).

While deinstitutionalization appeared to present a new and less pessimistic approach, what occurred in reality was the exporting of the same "medical model" rationale that underscored the old hospitals. What was not exported

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was a sufficient proportion of the money that had been spent for decades on the asylum approach to care. The World Health Organization (WHO [9]) reports that CC expansion did not keep pace with asylum closures in many countries, leaving a "service vacuum" wherein significant numbers of patients receive inadequate support. In the UK, for example, a review by the Care Quality Commission identified numerous critical failings, including breaching of patient rights, and substandard inpatient, crisis, and out-of-hours care (10). Furthermore, while CC was originally presented as synonymous with an increase in patients' civil rights, numerous countries have introduced increased legislation for granting powers of coercive medical treatment outside the hospital. For example, supervised compulsory treatment orders (CTOs) are commonly used to enforce medication adherence in one's own home, despite their ethical implications and inconsistent evidence of benefit (e.g., impact on medication compliance, number and duration of hospital admissions, and quality of life [11]). Although these compulsory powers were partly prompted in response to a small number of highly-publicized assaults perpetrated by psychiatric patients, concerns have been expressed that authoritarian, coercive treatment models (whether administered chemically via medication or physically via enforced hospital committal), may actually increase risk through reducing patients' incentive to engage with services (12).

The perceived failings and inadequacies of CC have provoked significant levels of debate in the past 50 years (13). On one hand, this dialogue can be framed in practical and procedural terms: e.g., how services are commissioned, organized, and delivered. However, the focus of this article is on an alternative aspect: the ideological basis on which CC operates and, crucially, what changes we believe are necessary to drive the shift towards more humane and effective mental health services.

THE NEED FOR A PARADIGM SHIFT

It is our contention that the biomedical underpinning on which CC is based has resulted in a general exporting of the asylum mindset – the confinement and control of supposed biological diseases – into community settings. We would further suggest that a major difficulty with contemporary models of CC is that they are premised within what has been deemed "a technological paradigm" (14) or what the psychologist Lucy Johnstone characterizes as "patients with illnesses" as opposed to "people with

problems" (15). Here we reiterate the work of Bracken et al. (14, p. 430), who outline the assumptions of this paradigm as it applies to psychiatry in the following terms:

1. Mental health problems arise from faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual.
2. These mechanisms or processes can be modelled in causal terms. They are not context dependent.
3. Technological interventions are instrumental and can be designed and studied independently of relationships and values.

While critics of this framework do not deny that some patients find it beneficial, a major assertion is that other ways exist of conceptualizing distress (specifically, as a response to life events rather than a biogenetic disease); that these are scientifically and morally justified; and that for many can be a turning point in the recovery journey. In the following sections, we outline some of the major limitations with the technological paradigm's hypotheses (for further discussion, see also 16, 17, 18).

ABNORMAL PROCESSES WITHIN THE INDIVIDUAL

In general medicine the technological paradigm is applied to treat physical processes, wherein precise empirical evidence usually - although not always - provides doctors with logical grounds for a chosen intervention (e.g., as in the case of cancer, cardiac disease, or AIDS). However, this is not equally applicable for functional psychiatric diagnoses, for which no categorical, aetiological models have ever been documented. As observed in a paper published in The British Journal of Psychiatry, authored by 29 practicing psychiatrists: "We suggest that this paradigm has not served psychiatry well. Ignoring fundamental epistemological issues at the heart of our models does not make them go away. Moreover, it does not yield results that are consistent with the demands of evidence-based medicine" (14, pp. 430-431).

For example, in contrast to continuing innovations in other medical disciplines, no mechanistically novel psychiatric drug has been marketed in over three decades, a situation largely explicable through a continuing lack of knowledge about the pathophysiology of mental health problems (19). It is further notable that the major classes of psychotropic agents (antipsychotics, antidepressants, anxiolytics) were discovered on the basis of chance clinical observation rather than targeted development (e.g., preclinical or genetic data, disease pathophysiology drawn

from animal models), and thus do not meet the criteria for modern drug discovery methods (19). In turn, the most popular and prevailing locus for mental health problems, that of the "chemical imbalance," is largely attributable to the modes of action of these drugs (e.g., the discovery that antipsychotic compounds block D2 receptors is the basis of the "dopamine theory of schizophrenia" which claims hallucinations and delusions are caused by hyperactive signal transduction in the dopaminergic system). However, as noted by Jackson (20), this is essentially a model in which a condition has been hypothesized to account for a drug mechanism, rather than designing a drug to treat a specific disorder. As Kendall, writing in *The British Journal of Psychiatry*, describes it: "the story of the atypicals and the SGAs [second-generation antipsychotics] is not the story of clinical discovery and progress; it is the story of fabricated classes, money and marketing" (21, pp. 266-267).

In an absence of identifiable biomarkers, psychiatry relies on a system of symptom-based diagnosis and treatment that Thomas Insel, the director of the National Institute of Mental Health (NIMH), has likened to "creating diagnostic systems based on the nature of chest pain or the quality of fever," additionally noting that symptom-based diagnoses are increasingly rare in other medical disciplines because they rarely designate the most suitable intervention (4). The pervasive problems with the reliability of psychiatric classification are well-documented (22), and are probably best typified in clinical practice by the familiar sight of patients with numerous conflicting diagnostic labels. Indeed, in response to the publication of the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), NIMH issued a statement of intent to re-orientate its research away from DSM classifications in favor of assembling genetic, imaging, physiologic, and cognitive data (while also acknowledging that sufficient information does not currently exist to develop such a system [4]).

Taken together the technological paradigm reflects a tendency towards medicalizing and pathologizing human experience (14), despite an absence of adequate empirical data to justify this approach. This is a type of reductionism famously and powerfully critiqued since the 1960s in the work of the "anti-psychiatrists" Laing and Szasz, although more recent critiques were apparent following the publication of DSM-5, including an international statement of concern (23) as well as grave reservations from the Chair of the DSM-IV taskforce (24). In a related point, Bracken et al. (14) also note how

the assumptions of the technological paradigm have made psychiatry vulnerable to corruption through its close alliances with the pharmaceutical industry, which in turn risks undermining trust and integrity in the profession.

This is not to deny that some individuals with mental health difficulties evince a series of detectable neurophysiological changes. Nor is it to suggest that neuroscience has no role in advancing understanding of the causes of, and effective treatments for, mental health problems. However, as will be discussed below, a key issue is considering these changes within their appropriate context.

ABNORMAL PROCESSES ARE INDEPENDENT OF CONTEXT

According to the technological paradigm, mental illness can be modelled in universal causal terms independently of individual circumstances (14). This can be seen with the emphasis on faulty biological mechanisms discussed above, as well as the discipline of "descriptive psychopathology," a phenomenological tradition that accentuates the form of psychiatric symptoms rather than their subjective content. In fact, evidence in the last decade has demonstrated beyond reasonable doubt that mental health problems are associated with a broad range of adverse contexts, particularly (but by no means exclusively) childhood adversities. For example, the WHO World Mental Health Survey (n=51,945) reported strong associations between childhood maltreatment and first onset of 20 DSM-IV disorders (25), with childhood abuse additionally increasing the likelihood of greater clinical severity (e.g., self-harm and suicidality, hospitalization frequency and duration, medication dosage, global symptom burden [26]). It is important to emphasize that such associations also extend to psychotic experience, despite its longstanding status as a primarily biogenetic condition, and that these relationships are not only dose-dependent but remain significant when controlling for a broad range of confounding clinical and demographic variables (for review see 27, 28, 29). In turn, psychotic symptoms have been found in some cases to be thematically congruent with previous experiences of adversity (30, 31, 32), such as hearing the voice of a perpetrator. Indeed, seeking intelligible links between adverse life events and the content of psychotic symptoms is a therapeutic aspect emphasized during psychological formulation, on the grounds that "[s]uch links often provide indications of long-standing unresolved difficulties and associated nega-

tive self-evaluations…which may be closely intertwined with processes maintaining delusional beliefs and voices and may underpin aspects of the emotional reaction" (33, p. 127; see also 34, 35).

Given the substantial evidence for the impact of adversity on the brain (36, 37, 38), the technological paradigm's essentialist framework - that neurological and biochemical abnormalities observed in adult patients have a causal etiological status independent of psychosocial circumstances – must clearly be called into question. An example of a contrary approach is the Traumagenic Neurodevelopmental (TN) model of psychosis (39, 40), which outlines the reciprocal interactions between environmental stressors and cognitive, affective and biological elements in the individual. By demonstrating the profound similarities between functional/structural abnormalities in the brains of abused children and those of adult psychosis patients (which in turn correspond to differences between psychotic patients and healthy adults, and traumatized and non-traumatized children) the TN demonstrates that adverse events cannot reasonably be minimized to "triggers" for a genetic predisposition, but should be considered as causal events in and of themselves. In terms of the technological paradigm the TN is interestingly placed, because while it conforms to assumptions that mental health problems arise from disordered processes that can be modelled in causal terms, it also locates these processes in the psychosocial context in which they arise. This is a crucial difference, for while the TN model is empirically supported (39, 40), it is also able to highlight the capacity of positivistic approaches to decontextualize misery and mental distress.

INSTRUMENTAL INTERVENTIONS

Technological approaches to psychiatric care prioritize instrumental interventions that supposedly address explicit disorders, with factors like narrative, subjective meaning, and interpersonal relationships often minimized (14), or even dismissed entirely (41). This is evident in the case of pharmacotherapy, but also in some forms of cognitive therapy, and is a framework that Radden (42) likens to "a repair manual" of mental health. In turn, Thomas and Longden (17) argue that such models have prioritized empiricism in a way that stifles the caring impulse; and as such are fundamentally incapable of engaging with human suffering in a principled way.

While not denying that some patients find pharmacotherapy helpful, it is important to acknowledge the lack of evidence for the capacity of psychiatric drugs to successfully target and remedy a hypothetical "chemical imbalance" (43), as well as findings that pharmacology has only a partial influence on ameliorating complex mental health difficulties (5, 44, 45, 46). Furthermore, many benefits associated with mental health treatments are robustly attributable to non-technical aspects (14). For example the placebo effect – a complex phenomenon linked to non-specific factors like hope, positive expectancy, and personal meaning – is known to have an impact in trials of antidepressants (47, 48), antipsychotics (49) and electroconvulsive therapy (ECT [50]). Likewise the nature of the therapeutic alliance can often be a better predictor of outcome than the specific, technical properties of a given therapy – a phenomenon known as "the equivalence paradox." For example, a comparison of 5,613 cases involving cognitive behavioral therapy (CBT), person-centered, or psychodynamic therapy over three years found that the therapeutic alliance accounted for the largest proportion of variance in clinical outcomes, with no specific technique emerging as superior (51).

Other non-specific factors suggested to influence psychotherapy outcomes include individual client factors, such as resilience, self-esteem and coping skills (52), and extra-therapeutic events (53), although it is the therapeutic relationship that tends to show the strongest associations. For example, a recent RCT of 308 patients treated for acute psychosis has demonstrated that the quality of the therapeutic alliance in both CBT and supportive counselling has a causal effect on symptom outcome, with poor relationships being actively detrimental (54). Factors deemed particularly important include cooperation, collaboration, empathy, and responsiveness (55), although these are not limited to psychotherapy; a good relationship with one's prescriber is likewise associated with better outcomes in drug treatment (56-58). However, the benefit of compassionate interactions that nurture a sense of confidence, connection and autonomy is by no means a new discovery; its value was recognized as early as the 18th century in the concept of "moral therapy," a humane (albeit paternalistic) alternative for the care of asylum inmates. Historians generally agree that the promotion of "kindness, dignity, and decency" enjoyed striking success in a pre-pharmaceutical and pre-therapy age. For example, from 1833-1853 the Worcester State Hospital in the United States discharged 71% of first-episode patients as "cured," with rates of 59% for those

with longer pre-admission disturbance, and only a minority identified as chronically ill (59).

MOVING FORWARDS: MODELS OF PSYCHOSOCIAL CARE

Taken together, a growing body of evidence refutes the idea that a "technical idiom" (14) is a suitable way to approach CC delivery. Indeed, as discussed, there is reason to believe that the primacy of technological paradigms may actually hinder recovery for some service users. Dillon (60) summarizes this paradox in the following way: that one's 1) emotional crisis (a supposed biogenetic abnormality) is responded to with 2) denial (the emotional meaning of experiences like voice hearing or unusual beliefs are ignored and the role of painful life events disregarded), which is followed by 3) insight (the patient accepts their biological illness), followed by 4) "recovery" (symptoms are controlled by medication), and which finally results in 5) relapse (the initial crisis continues to reoccur, for in addition to the person's underlying, unresolved emotional problems, they may also face stigma, exclusion, medication side-effects, and a sense of hopelessness). Thus a cycle of maintenance and chronicity may become established.

Nevertheless, despite limited scientific evidence to justify it, substantial accounts of the harm it can cause, and extensive evidence for the role of psychosocial factors in mental distress, technological approaches to psychiatric care continue to endure. There are numerous influences that contribute to sustaining this dominance. While a full account is beyond the scope of the current article, they include (but are not limited) to the following factors, summarized thus by Rapley et al.: "The medicalization of suffering and difference thrives because it sanitizes and simplifies" (61, p. 4).

1. **Political interest.** It is politically convenient for policy makers to emphasize individual biology in ways that decontextualize mental health problems and thus deflect scrutiny from damaging social systems. Childhood abuse and neglect, adulthood assault, poverty, and discrimination have devastating personal consequences, yet medicalizing subsequent distress permits a level of denial and distancing that absolves those in power of responsibility for addressing injustice and instituting legislative change.

2. **Economic interest.** The influence of the pharmaceutical industry on psychiatric practice, training, and clinical research has attracted sustained concern and criticism (62). Nevertheless, financial motives for perpetuating biological models of mental distress are considerable, and may be one of the most powerful barriers to change. For example, in the United States alone sales of psychiatric medications generated $25 billion in 2011 (63): for comparison, the net income for the Google corporation in 2012 was $10.74 billion.

3. **Professional interest.** Constructing a clinical problem (whether in terms of disrupted biological systems or dysfunctional psychological mechanisms) promotes the need for specialist, scientific expertise. As such, many aspects of the "Psych" professions are premised on emphasizing problems within the individual as the main target for intervention, wherein contextualizing mental health problems and acknowledging damaging social/political realities presents profound challenges to the legitimacy of its "self-defined subject matter" (64, p. 37).

4. **Interpersonal interest.** Some families may have a vested interest in conceptualizing their relatives' difficulties as an illness rather than the result of damaging life events. However, with the exception of caregivers who deliberately inflict cruelty or neglect, locating the origins of distress within the family of origin should not be seen as a blaming impulse. Conversely, recognizing the impact of poverty, attachment disturbances, social conflict, and intergenerational trauma can help to acknowledge and address the needs of both patients and their families in more restorative ways (65).

5. **Individual interest.** The process of societal/political denial and distancing also operates on an individual level. Emphasizing a categorically different group characterized by fundamental biological/genetic abnormalities drives the reciprocal mechanisms of fear, avoidance, and scapegoating which, in turn, exaggerates the differences between "the mad" and "the sane" and denies the dimensionality of emotional distress. On one hand, this protects our need to see ourselves as different from "the mentally ill," but is also a way to avoid contemplating the need to address violence and injustice within one's society. In turn, patients may also internalize medical paradigms, either to protect themselves or their families from painful realities, or to devolve responsibility for "cure" to mental health services in an unconscious attempt to meet a need for caring input that may have previously been withheld (e.g., during childhood).

Taken together, there are clearly considerable influences that contribute to maintaining a status quo, both in CC

and approaches to mental health more generally. Is there any cause for optimism about the feasibility of a paradigm shift?

Although the progression towards more psychosocially responsible services is protracted and slow, there are still grounds to note important developments in recent years. Firstly, this includes a notable growth in academic interest for psychosocial approaches to complex mental health difficulties (e.g., the number of research articles considering links between schizophrenia and trauma has more than doubled in the past ten years compared to the previous decade[i]). While the lengthy interval between research findings and practical implementation is well recognized in applied disciplines, there is nevertheless growing indication that these ideas are beginning to be partially fulfilled at a service level. In the UK, for example, National Health Service guidelines advocate asking all psychiatric service users about trauma exposure (66); and the British Psychological Society's Division of Clinical Psychology has emphasized the utility of psychotherapeutic approaches to so-called pathognomonic symptoms of schizophrenia, like voice hearing and delusions (35). While such frameworks do not yet constitute standard practice, Boyle makes the important observation that "the evidence causally linking social context to distress…is plentiful and robust, so that there is a limit to how far clinical psychology and psychiatry can avoid it without raising questions about their status as evidence based disciplines" (64, p. 30).

There are also many signs of growing unity and fellowship between groups of individuals wishing to promote non-technical paradigms to mental distress. This includes influential survivor-led organizations, such as the Hearing Voices Movement (intervoiceonline.org), Mind Freedom International (mindfreedom.org), and Mad in America (madinamerica.com), in which coalitions of survivors and their allies critique reductionist approaches to mental wellbeing, and raise awareness of the perceived abuses and violations associated with them. Professional bodies like the Critical Psychiatry Network (criticalpsychiatry.net) and the International Society for Psychological and Social Approaches to Psychosis (isps. org) likewise advocate for progressive reform within the mental health system. In turn, research shows that members of the public across the world (with the general exception of the United States) show a consistent preference for psychosocial explanations and treatments for mental distress over technical, biomedical ones (67).

Testimony from those with lived experience of mental health problems has also successfully highlighted the inadequacy of technological models for understanding the nuances of distress and recovery. For example, contrary to a clinical focus on symptom cessation, the concept of "personal recovery" emphasizes factors like connectedness, hope, identity, meaning in life, and empowerment (68) – factors which can, and do, occur outside of statutory services. In turn, survivor-led recovery literature challenges assumptions that the impact of mental health crises are inevitably and exclusively negative which, while not negating the fear and pain many patients experience, emphasize how experiences of mental distress, including psychosis, "have ultimately informed and augmented… wellbeing (e.g., through a heightened capacity for political engagement, creativity, compassion, fortitude, and self-knowledge)" (69, p. 25). There is also the growing awareness that clinical, technologically-led treatments are only one of several possible routes to recovery (68), as well as the recognized fact that people with diagnosable mental health problems may often live successfully outside of psychiatry (e.g., they are not distressed by their experiences/actively value them; or they have a non-medical or non-psychological framework, such as spiritual or cultural beliefs). Taken together, these are diversities and complexities that purely technological paradigms are unable to successfully accommodate.

As Bracken et al. express it, "The evidence base is telling us that we need a radical shift in our understanding of what is at the heart (and perhaps soul) of mental health practice…good psychiatry involves active engagement with the complex nature of mental health problems, a healthy scepticism for biological reductionism, tolerance for the tangled nature of relationships and meanings and the ability to negotiate these issues in a way that empowers service users and their carers" (14, pp. 432-433). In this respect there are several examples of holistic, sociocentric services that demonstrate the feasibility of working outside a technological paradigm. These include the Sanctuary Model (70), the Soteria paradigm (71), and Open Dialogue family and network approach (72), all of which are configured at organizational and clinical levels to promote psychological growth and reconstitution, and which broadly emphasize communal, social, and dialogical processes with minimal medication use. Furthermore, while options for patients and professionals enmeshed in more conventional services can appear limited, there

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i. Based on a Scopus search (schizophrenia AND trauma OR abuse): 5,304 articles published between 2004 and 2014; 2,166 published between 1993 and 2003.

Table 1. *Practical strategies for facilitating a paradigm shift in mental health care*

Individual level	• Inquiring about service users' lives and how they think adversity exposure may have impacted on their current difficulties.
	• Asking service users what they need and what type of support they feel would be most helpful.
	• Encouraging colleagues to focus on recovery rather than pathology.
	• Forming alliances with progressive professional organizations, and groups of families and service users.
	• Avoiding language that is stigmatizing (e.g., "schizophrenic") or pathologizing (e.g., "illness").
	• Lobbying for change to local and national government, mental health service managers, and in social and corporate media.
Service/provider level	• Active involvement of service users in the design, management and evaluation of services.
	• Facilitating service user-led training and research.
	• Refusing to accept money from the pharmaceutical industry.
	• Supporting psychiatrists to share the responsibility for risk management.
	• Initiating or supporting relevant psychosocially-focused training.
Societal level	• Advocating for reduced coercion and involuntary treatment in services and legislation.
	• Advocating for primary prevention (e.g., child protection, domestic violence services, anti-bullying policies).
	• Publically emphasizing the psychological consequences of victimization,
	• inequality, discrimination and other forms of injustice.
	• Drawing attention to attempts by the pharmaceutical industry to influence
	• mental health policy, research, and service provision.

Adapted from: Read, J, Dillon J. Creating evidence-based, effective and human mental health services: Overcoming barriers to a paradigm shift. In Models of madness: Psychological, social, and biological approaches to psychosis (eds. J Read, J Dillon): 392-407. London: Routledge, 2013.

are still avenues for facilitating and promoting positive change. Examples of potential strategies are presented in Table 1.

CONCLUSIONS

This article began with an account of the beleaguered status of modern psychiatry and, by extension, the models of CC over which it presides. In turn, we have outlined some of the major theoretical and practical weaknesses of its associated technological paradigm, as well as indications of – and practical suggestions for – the institution of paradigm change. Taken together, this type of discontent supports the contention that a conceptual shift in mental health is not only necessary, but also feasible, and inevitable. In doing so, we do not suggest that empiricism has no place in mental healthcare, or that biomedical theory and practice have no benefit. However, as we have outlined, there is also evidence that a radical reappraisal is needed of how these factors are currently applied within CC.

In a paper considering the historical links between schizophrenia, trauma, and dissociation, the psychologist Andrew Moskowitz (73, p. 351) applies the reasoning of the philosopher Thomas Kuhn (74) to this very question. According to this perspective, intellectual and practical changes occur when incongruities and contradictions undermine the basic hypotheses upon which the "old

rules" of a particular discipline were established. The ultimate outcome is conceptual revolution, and a shift from "ordinary to extraordinary" in research, theory, and practice:

Kuhn (1970) argued that paradigms change and a scientific revolution ensues when three conditions are met: (a) a period of crisis develops in which the paradigm fails to adequately answer questions considered fundamental; serious 'anomalies' occur in which phenomena not clearly compatible with the paradigm are observed; and, importantly, (c) a suitable alternative paradigm that explains many of the previous findings and at least some of the observed anomalies comes to light. Kuhn saw scientific revolutions as taking time to resolve; he argued that changing such strongly held beliefs involved a process of persuasion and fundamental reorganization not unlike that of religious conversion: 'Conversions will occur a few at a time until, after the last holdouts have died, the whole profession will again be practicing under a single, now different paradigm' (Kuhn, 1970, p.152).

In a recent paper asking the question "How much evidence is required for a paradigm shift in mental health?" (41, p. 477) two authors of the current paper also invoked Kuhn's work:

As Kuhn pointed out, an accumulation of evidence contradicting a long-standing paradigm is not sufficient, because the 'last holdouts' have a myriad of strategies to minimize, distort and deny the new evidence. He referred

to the need for less 'scientific' processes such as enthusiasm and persuasion. Perhaps the most exciting, and persuasive, recent development has been the rapid development of the Hearing Voices movement (www.intervoiceonline.org). Many voice hearers all over the world, tired of waiting for the paradigm shift that the research evidence demands, are supporting one another and training mental health professionals how to help when asked.

The closing of the old hospital asylums, and the accompanying move to CC, had the potential to facilitate genuine change. Yet the hospitals, although smaller, still remain the lynchpin of services. And beyond the hospital, the medical model and its decontextualized technologies still dominate, along with the constant threat of compulsory treatment. Growing doubt and dissatisfaction around these technological approaches to mental health are, however, fuelling the search for more suitable models with which to theorize and respond to human distress. The challenge for the next generation of practitioners is to extend beyond reductionist biological models and acknowledge the complex influence of psychosocial, political, relational, and cultural components in which mental health problems are inevitably embedded, and then to develop treatments and supports that address those real causes of human distress. It is both as straightforward – and as complex – as that.

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Author Contributions

Eleanor Longden: drafting and critical revision; final approval.
John Read: article conception; drafting and critical revision; final approval.
Jacqui Dillon: drafting and critical revision; final approval.

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Commentary on "Improving Community Mental Health Services: The Need for a Paradigm Shift" by Longden et al.

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We appreciate and welcome Longden, Reade and Dillon's critique of the Community Care approach to mental health services. This is a well-written, carefully thought out critique that touches on many of the failings in our mental health system, and we agree with a number of the points made. In the following commentary, we will point out some issues that we believe require further thought or clarification.

First, we would like to raise the question of whether all of the concerns that the authors raise with the Community Care model are actually failings of the model as it was originally conceived, or with the way in which it was implemented. Toward this end, it would be helpful if the authors could have discussed some of the founding documents of the "architects" of the movement to establish Community Care. While we are not aware of documents relating to how Community Care was envisioned in other countries, in the United States there was a document that offered a clear statement of intent regarding a transition from an institutional to community-based system: Action for Mental Health (1), a report published in 1961 issued by the Joint Commission on Mental Illness and Health, which was convened by the United States Congress. The recommendations of the report were a major factor in the passage of the Community Mental Health Act of 1963, a federal initiative that led to the founding of community mental health centers throughout the United States, a key component of "deinstitutionalization." Although the lore about this document has in some ways taken on a life of its own, it is helpful to review it and be reminded of some of the principles undergirding the Community Care model as envisioned by its founders. In reviewing this document, we noted that there is a focus on four areas that were subsequently almost completely ignored in the implementation of Community Care in

the United States: 1) a belief in recovery (the authors stated "the late nineteenth-century medical dictum that schizophrenia is a hopeless, incurable disease…is baseless"), 2) a focus on community stigma (discussed as "social rejection" in the document) as a barrier to recovery and community participation, and a discussion of the need to develop initiatives to combat it, 3) an explicit anti-coercive stance (the authors emphasize that coercion is dehumanizing and should be used only as a last resort in instances of danger to others), and 4) a recommendation that, along with professional services, informal community supports, including "ex-mental patient organizations" (now called peer support or consumer-operated services), had an important role to play in helping people with mental illness achieve better community participation. Whether these areas received adequate consideration regarding how to successfully translate these ideals into practice at the clinical level remains an open question. All of these emphases are ones that we find laudable, and that we believe they suggest that those who envisioned the Community Care model were not simply seeking for the State Hospital approach to be transitioned into the community.

Second, we think that, in making its point, the article over-emphasizes certain aspects of the current mental health service system and downplays others. For example, the authors highlight the current system's emphasis on mandatory treatment with antipsychotic medication and psycho-legal coercive practices such as Community Treatment Orders (called "Assisted Outpatient Treatment" in the United States). We are in agreement that these practices are highly problematic, as they reflect the philosophy that the mental health system is an agent of social control. However, they do not mention other aspects of the current system that reflect a different tradition, such as the growing

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emphasis on supported employment, peer support or consumer-operated services, an increasing emphasis on trauma-informed care, and the growing use of psycho-social treatment approaches such as wellness self-management and cognitive-behavioral therapy. Although the authors may see these practices as incompatible with the current biomedical paradigm and reflective of the move toward a new paradigm, from our perspective (as individuals who both work within the mental health system and study ways to make it better), the fact that these types of services exist in the same mental health system reflects that the current mental health system lives in contradiction and has "internal conflicts" that need to be resolved. Essentially, this is the contradiction between what could be called the "principle of healing" (that the purpose of the service system is to help people with mental illness live the best possible lives in the community) and what could be called the "principle of social control," which views the purpose of the mental health system as protecting members of society from the putative dangerous behavior of people with mental illness. This contradiction is quite evident in the state where we work (New York) which funds services based on maximizing "choice" and self-determination at the same time that it is heavily invested in Assisted Outpatient Treatment – a psycho-legal mechanism that coerces people to take medication under threat of involuntary hospitalization. If the mental health system were able to resolve this conflict and realign itself in totality with the principle of healing, based on person-centered and recovery-oriented principles, it might be that we would be able to better see if the Community Care paradigm is something that should be abandoned.

Finally, we had questions about what the authors thought should replace the Community Care model. If there were a paradigm shift, what would the new system of care look like, and how it would differ from the current practices in use that are aligned with the "principle of healing"? It is clear that this new model would not rely primarily on biomedical treatments, and it would use a psychosocial perspective, but what that approach would look like in practice was vague. For example, would psychiatric medications as a self-management tool for dealing with bothersome symptoms be permitted in the new system? We would have appreciated a more clear articulation of what a new service system would look like under the new paradigm.

In conclusion, we welcomed the authors' critique and believe that it points to the need for much more "soul-searching" in the current mental health system. It has been over 50 years since the passage of the Community Mental Health Act and, although the system has moved away from exclusively institutionalized care, we ought to reach a consensus to help us steer the field toward person-centered, recovery-oriented services. Currently, the system continues to employ a diverse set of practices that are uncoordinated at best and completely contradictory at worst (confusing those that we serve and leading them to often rightfully conclude that "you people can't get your act together"). Indeed, the mental health system needs to clarify what its purpose is, and having determined what it believes in, take a stand for its beliefs.

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Community Mental Health as a Population-based Mental Health Approach

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ABSTRACT

Background: Mental health services for youths in Singapore were challenged by accessibility and resource constraints. A community-based mental health program working with schools and other partners was developed to address the population needs.

Aim: To describe the formation of a community-based mental health program and evaluate the program in terms of its outcome and the satisfaction of the users of this program.

Methods: Based on needs analyses, a community multidisciplinary team was set up in 15 schools to pilot a new model of care for youths. Implemented progressively over five years, networks of teams were divided into four geographic zones. Each zone had clusters of 10 to 15 schools. These teams worked closely with school counselors. Teams were supported by a psychiatrist and a resident. Interventions were focused on empowering school-based personnel to work with students and families, with the support of the teams.

Results: 4,184 students were served of whom 10% were seen by the school counselors and supported by the community team. Only 0.15% required referral to tertiary services. Outcome measured by counselor and teacher ratings showed improvements in the Clinical Global Impression scale and Strengths and Difficulties Questionnaire. These included reductions in conduct problems, emotional problems, hyperactive behaviors and peer problems. Furthermore, prosocial behavior also significantly improved. Preliminary cost effectiveness analyses suggest that community treatments are superior to clinic interventions.

Conclusion: There is evidence that a population-based community mental health program with schools can be implemented through a multisectoral approach with good outcomes that is cost effective.

INTRODUCTION

Singapore is a small island nation with a land area of slightly over 740 square kilometers at the tip of the Malaysian Peninsula. Today, Singapore is one of the wealthiest countries in the world, ranked 36th in per capita GDP (1). The state of physical health in Singapore is good by international standards, ranked by the WHO as 6th in the world in 2000 (2). Singapore also achieved its good physical health standards at a comparatively low cost, ranked by the Economist Intelligence Unit as 2nd among 166 countries in 2014 (2). However, suicides among youth was a major public health issue (3). Mental health disorders contributed to 11% of the Disability Adjusted Life Years (DALYs) in a study in 2004 (4), which is similar to global trends (5), and is expected to rise in the next decade.

MENTAL HEALTH SYSTEMS

In Singapore, private general practitioners predominantly provide primary mental healthcare, while secondary and tertiary mental health care is mainly at the public hospitals (6). The Institute of Mental Health (IMH) is the national specialty center for mental health disorders. Even though there are a variety of treatments available, only 31.8% of people with such disorders seek professional treatment, with a prolonged wait until treatment (7). Disease burden measured by DALYs showed that

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mental health disorders in youth contributed to three out of the five top conditions for children aged 0 to 14 years (4). The top five conditions seen at the Institute of Mental Health were Attention Deficit Hyperactivity Disorder (ADHD), stress related disorders, autism, depression and anxiety disorder (8). The consequences for untreated childhood mental health disorders are associated with academic failure, social dysfunction, poor peer relations, substance abuse, and school dropout (9). School failure is among the most common reasons for referral to child mental health services and this need continues to grow (9). The reasons for the long delay between the onset of a mental health disorder and entering into treatment could be associated with the failure to identify the illness, stigma, and the poor accessibility (10). Therefore, mental health disorders should be targeted by population-based health interventions (8).

DEVELOPMENT OF POPULATION HEALTH STRATEGIES

The Government of Singapore recognized that a concerted national program was necessary to address the multi-faceted needs of the population. These include the need to maintain good mental health, identify mental health disorders early, and to establish a comprehensive intervention program in primary, secondary and tertiary health care settings. This resulted in the National Mental Health Blueprint in 2007. Singapore's approach deviated somewhat from the WHO's Mental Health Gap strategy (11) of arming primary care physicians with skill sets to manage mental health problems in the community. The reason is that only about 1 in 5 persons with mental health conditions approached primary care physicians for help (12).

The initial focus of the Blueprint for children and adolescents was on the school system, as education is compulsory and schools form an obvious basis for preventative as well as early intervention efforts (13). Singapore has 385 schools clustered in groups of 10 to 15 schools based on geographical regions. Groups of 7 clusters form a school zone and there are four zones in the North, South, East and West. Starting with a prototype concept in 2007 in one school cluster of 15 schools in the North Zone, a pilot team was formed. This consisted of clinicians (nurses, occupational therapists, medical social workers and psychologists) led by a psychiatrist with a small administrative support team. They met with every school's senior management (which includes the principal and the teacher who oversees counseling services for students) in the pilot cluster and mapped out the school-based needs. A single focal point of contact by schools was established. These single points of contact were in school support teams and are usually school counselors or heads of pastoral care in the schools. The rest of the school support team was made up of learning support staff and teachers. The job of the school support team was to look at potential mental health issues and refer them to the mental health community team for support. Mental health teams worked with schools and were mobile in their support, organizing school or even home-based conferences to help students with issues.

In the pilot program, behavioral and learning disorders were the issues that first surfaced. The teams decided to work on ADHD as they formed the bulk of school identified issues. ADHD was also well understood by schools as a learning related disorder. Specific training for identification and treatment of ADHD was organized. This consisted of lectures, hands on workshops with a multidisciplinary training approach, bringing together mental health team members, school support teams and primary care physicians and community pediatricians. Processes and pathways for managing students with suspected ADHD were created including the development of a clinical practice guideline for ADHD (14, 15). Using ADHD as the starting point for introducing the approach to diagnostic formulation and treatment planning, school counselors are then introduced to other common mental health disorders.

The pilot program ran for a year with great success and approval was given to scale it across the entire North school zone of almost 100 schools. Success was measured by good outcomes and satisfaction scores of school counselors and partners. The community mental health team called Response, Early Assessment and Intervention in Community Mental Health (REACH), was set up to target the entire school zone. At the same time, relevant non-governmental organizations (NGOs) were recruited to boost support in the community for school and social service linkups. Four NGOs formed the pilot group and additional funding was provided by the National Council of Social Services (an umbrella body that brings together social services and charities for coordination of social care in Singapore). The aim of this paper is to describe and evaluate the program in terms of its outcome (i.e., symptom severity, treatment response and cost effectiveness) and the satisfaction of the users of the program. This can hopefully provide the reader with a blueprint for developing similar community programs.

METHODS

REACH TEAM COMPOSITION

The REACH teams were based in three hospitals selected because they were already running some form of secondary or tertiary mental health services for children and adolescents. The pilot team was part of the psychiatric hospital while the newer teams came from a university-based health system and the national pediatric hospital. The North, South, East and West team respectively employed 1.51, 1.51, 0.5 and 1.3 full-time equivalent (FTE) medical staff; 3, 2, 1 and 1 FTE nurses; 5, 4, 5 and 8.2 FTE psychologists; 2.5, 2, 2 and 0 FTE social workers; 1.5, 3, 1 and 2 FTE occupational therapists; and 2.6, 1, 1 and 1 FTE administrative staff. This composition depended on what the needs were and availability of experienced staff to fill the positions.

REACH INTERVENTIONS

The teams developed a systematic assessment process not dissimilar to a psychiatric evaluation in a clinic involving interviewing the child, parents and teachers in school or at home. A diagnostic formulation follows such an evaluation in which a multidisciplinary treatment plan is devised. Specific targeted interventions may involve either individual treatment of family work using a cognitive behavior framework or provide group therapies for common problems such as anxiety or anger issues. All interventions follow an evidence-based approach and have been described elsewhere (13). For example in ADHD, the teams formulate treatment based on the Clinical Practice Guidelines by the Ministry of Health (15) and offer parent training and school-based educational support as first line interventions. Interventions that require tertiary care such as specialist inputs for medications and intensive multidisciplinary treatment or inpatient care are then referred to the hospitals serving the school region.

SAMPLE

This is a retrospective review of the REACH program from its inception in 2007 until February 2015. A total of 4,184 students (2,801 males and 1,360 females) aged between 7 to 20 years were referred to the REACH program during this period. Outcome ratings were obtained from 3,156 students. A total of 385 schools with 499,295 students were involved in the project. School counselors saw almost 55,000 students annually (16) of whom almost 10% were referred to the REACH teams working with counselors and 955 students were eventually referred to the hospital for specialist care. Annually, an average of 7,500 calls were received by the REACH helpline. The mental health conditions referred to REACH were not dissimilar with IMH's top conditions and include ADHD, anxiety disorders, stress related disorders, depression and autism.

MEASURES

A combination of measures was used to evaluate the program's outcome and cost effectiveness. These were identified by the clinical teams and tested with the school counselors and community agencies. Outcome ratings were completed by counselors, teachers, primary care physicians as well as the students receiving the service. Satisfaction ratings were also obtained from school counselors, primary care physicians and NGOs involved in the project.

OUTCOME MEASUREMENTS

Clinical Global Impression scale (CGI). The CGI was completed by the school counselor and was a commonly used psychiatric tool consisting of 2-item observer-rated scale that measures illness severity (CGI-Severity) and global improvement (CGI-Improvement). It was deemed a suitable tool due to its simple application. The reliability correlation for the Severity of Illness and Global Improvement subscales were moderate correlation (r ~ −0.47 to −0.66) and had strong concurrent validity, which suggest that the scale had good sensitivity to change over time (17).

Strengths and Difficulties Questionnaire (SDQ). The SDQ was completed by the child's teacher and has 5 subscales: Hyperactivity, Conduct Problems, Peer Problems, Emotional Problems and Prosocial Behavior. Reliability was generally satisfactory, whether judged by internal consistency (mean Cronbach a: .73), cross-informant correlation (mean: 0.34), or retest stability after 4 to 6 months (mean: 0.62) (18).

Children's Global Assessment Scale (CGAS). The CGAS was completed by the primary care physician and a measurement of overall severity of disturbance in children and adolescents. The inter-rater reliability correlation was 0.84 (19) and test-retest reliability of 0.83 (20).

Cost effectiveness evaluation. EuroQol-5 Dimensions (EQ-5D). The EQ-5D is a self-reported questionnaire that was used to measure an individual's health status and was also applicable to a range of health conditions and treatments (21). The EQ-5D was originally designed for the use in adult populations aged 18 and above. Nevertheless, previous research has demonstrated that it is possible to use the adult EQ-5D questionnaire to measure health

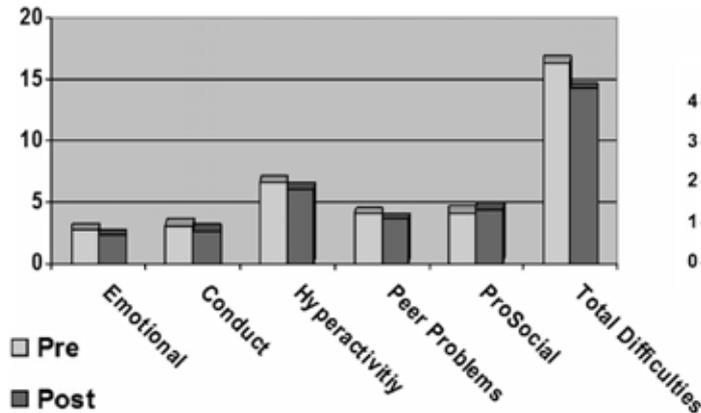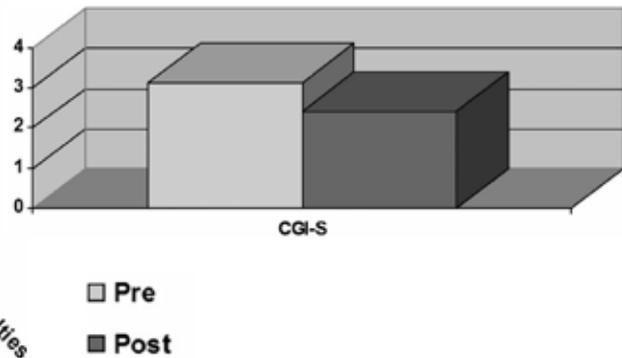Figure 1. *Improvement in 5 domains of SDQ ratings by teachers*

Figure 2. *Improvement in CGI Severity Scores by Counselors*

related quality of life (HRQOL) in children and adolescent (aged 8 - 11 and 12 - 18, respectively) (22). It should also be noted that the U.K. adult EQ-5D norm was chosen because it has been demonstrated to be both valid and reliable for use in Singapore (23).

User satisfaction and effectiveness of training. A questionnaire developed by REACH was used to measure users' satisfaction with the community teams as well as the effectiveness of training provided. These questionnaires covered the two main domains of effectiveness and satisfaction over a 4 point Likert scale of "strongly disagree," "disagree," "agree" and "strongly agree" (13). A similar questionnaire was used for primary care physicians and NGO staff working with REACH.

ANALYSIS

To monitor health outcomes (symptom severity and treatment response), pre-CGI/SDQ/CGAS scores were obtained during REACH Assessment, and post-CGI/SDQ/CGAS scores were obtained six months after the first assessment, regardless of the intervention. Students were categorized as "improved," "worsened" and "no change." Improvements were measured as a ratio of number of students "improved" against the total number of students seen. To determine the mean differences between the pre- and post-CGI/SDQ/CGAS scores, the mean scores for each year were calculated and a paired sample t-test analysis was performed using SPSS version 19 for Windows. To determine if the program was cost effective, EQ-5D utility scores were adjusted using multiple linear regression analyses for baseline socio-demographic variables (i.e., age, gender and ethnicity). The socio-demographic variables were selected based on research that suggests they are

important determinants of health related quality of life in Asian populations (23). Descriptive analyses of counselor and REACH partner satisfaction and the effectiveness of training were determined.

RESULTS

CLINICAL OUTCOMES

Of all the students referred to REACH, 77% of them improved on the CGI while 13.4% had no change and 6.5% had a worsening of symptoms. Paired-samples t-test analysis of the CGI revealed that the initial severity (M = 3.14, SD = 0.11) of the students referred to REACH were significantly lower six months later after REACH intervention (M = 2.42, SD = 0.06), t(7) = 17.88, p < .01.

Out of the total number of students referred to REACH, 63.3% of the students referred improved in SDQ scores whereas 29.9% had poorer SDQ outcomes and 6.9% experienced no change. Paired-samples t-test analysis on each of the five subscales of the SDQ revealed that the students significantly improved on all subscales. Specifically, the post emotional problem scores (M = 2.13, SD = .33) were significantly lower than the pre emotional problem scores (M = 2.76, SD = .33), t(7) = 3.51, p < .01, the post conduct problem scores (M = 2.61, SD = .70) were significantly lower than the pre conduct problem scores (M = 3.17, SD = .56), t(7) = 7.34, p < .01, the post hyperactivity scores (M = 6.01, SD = .41) were significantly lower than the pre hyperactivity scores (M = 6.71, SD = .46), t(7) = 12.18, p < .01, the post peer problem scores (M = 3.45, SD = .31) were significantly lower than the pre peer problem scores (M = 3.93, SD = .22), t(7) = 10.01, p < .01. Prosocial behavior differed from the other problem scores as this

reflected desired behaviors. Students referred to REACH had significantly higher post prosocial behavior scores (M = 4.47, SD = .70) than initial prosocial behavior scores (M = 4.05, SD = .30), t(7) = -2.27, p = .05. Finally, students who received REACH interventions had significantly lower post Total Difficulties Scores (M = 14.21, SD = 1.23) than initial Total Difficulties Scores (M = 16.58, SD = 1.44), t(7) = 11.47, p < .01.

Of all the students referred to REACH, 82.5% of them improved on the CGAS while 17.5% had no change and none had an increase in severity. Paired-samples t-test analysis of the CGAS revealed that the initial severity of disturbance (M = 60.35, SD = 8.80) of the students referred to REACH were not significantly lower six months later after REACH intervention (M = 79.30, SD = 3.20), t(3) = -2.3, p = 0.11.

COST EFFECTIVENESS EVALUATION

In a preliminary analysis of 71 youths diagnosed with ADHD who were seen in the REACH program, 53 were referred to a specialist outpatient clinic (classified as hospital-based care) and compared with 18 youths who were supported through the community teams (classified as community-based care) (14). The self-rated EQ5D was used in conjunction with the CGI to measure cost effectiveness. Results showed that community-based care was cost saving compared to hospital-based care at a negative Incremental Cost-Effectiveness Ratio of S$18,308 per Quality-Adjusted Life Year (QALY) gained and remained cost-effective over the 95% confidence interval of QALY estimates.

USER SATISFACTION AND EFFECTIVENESS OF TRAINING

The REACH team has trained 413 school counselors in a myriad of child mental health topics, thus increasing the counselors' capability in detecting, assessing and managing affected students. The school counselors have provided positive feedback about REACH with 98% rating satisfaction with the REACH support services and more than 95% rating the training provided as being satisfactory and effective.

DISCUSSION

There were 4,184 students served of whom 10% were seen by the school counselors and supported by the community team. Only 0.15% required referral to tertiary services. Outcomes measured by counselor and teacher ratings showed improvements in the Clinical Global Impression scale and Strengths and Difficulties Questionnaire. These included reductions in conduct problems, emotional problems, hyperactive behaviors and peer problems. Furthermore, prosocial behavior also significantly improved. Preliminary cost effectiveness analyses suggest that community treatments are superior to clinic interventions.

Prevalence of mental health disorders in Singapore is no different from other countries (24). Clinical services were developed based on high prevalence or high burden disorders. IMH is the largest provider of mental health services in Singapore, treating mainly severe behavioral disorders. This is not dissimilar to specialized child mental health clinics elsewhere (25). The initial implementation has shown that an almost equal number of behavioral and emotional disorders were recognized, suggesting that anxiety and depression were clearly unidentified and under-diagnosed. This potential treatment gap between what was being seen in specialist clinics and what was prevalent in the population suggests a need for some form of screening at school entry, and there is a need for research informing on how health screening may be conducted in an educational setting. Using ADHD as an entry point for schools to be introduced to mental health disorders is important because the principles of diagnostic formulation and treatment planning can be applied more widely to other psychiatric disorders and symptoms, particularly internalizing disorders, which have traditionally been poorly identified and managed in school settings (26).

The importance of using the school as a source of mental health promotion and interventions is well documented in most countries, including middle and low income countries (27). Most programs target specific areas (e.g., smoking or alcohol use) (28, 29) or focus on universal promotion of resilience and general wellbeing (28, 29). Such health promotion efforts use terms such as social emotional wellbeing and life skills training and many have good evidence of their effectiveness (30). Such programs are often delivered by teachers or school-based professionals in a curriculum-based educational process (31). There is a paucity of specific clinical programs that target difficulties and disorders and bring about collaboration between school-based mental health services provided by counselors and specialty mental health services in clinics and hospitals (32). Most of these examples are found in pilot schools, although they have not been scaled (33).

REACH can be said to be a successfully implemented national model with good outcomes. Our evaluation

demonstrates that there were significant improvements for students referred to REACH on a global level and not just symptom improvement. The improvements seen on CGI, SDQ and CGAS were statistically significant although there were no controls in the evaluation. We also did not have outcomes for all students as it was a challenge to obtain the ratings from counselors, teachers and the students themselves. We have also demonstrated that this program has evidence of being cost effective for ADHD treatment (34). Feedback from school counselors also revealed both acceptability of service as well as agreement to participate (13). With training in the form of a set of mental health curricula of almost 100 hours that could be provided over three years the counselors were also able to detect children displaying symptoms of mental disorders and refer them for specialist treatment.

REACH had an easily understood and identifiable brand for the country and schools took to the concept well. The regional deployment helped to phase in the preparation work and also allowed team formation to be ramped up in a manageable way. One of the challenges was developing a balanced team consisting of experienced mental health professionals with the innovative energy to do something that the individual professions were not accustomed to. Typically, a clinical psychologist's training does not involve mental health promotion and multidisciplinary work. The same can be said of nurses, medical social workers and occupational therapists, who are accustomed to working in hospitals and clinics. Team formation was decided by the lead psychiatrist of the teams and team members sourced from existing secondary or tertiary hospital-based systems. The partnership between the Ministry of Health and Ministry of Education was school-centered and progressively involved the 385 mainstream and special schools. This partnership involves sharing of resources so that school counselors are funded by education while community teams are funded by health. Although primary school education is mandatory, secondary school education is not. NGOs were recruited to monitor and reduce school dropout (about 1.5% of the school going population) and these NGOs were also involved in the community engagement of REACH. NGO resources were largely provided in the form of grants from the Ministry of Health and the Ministry of Social and Family Development. The combination of a specialized community team working with school-based counselors, local primary care physicians and social service NGOs in the vicinity of the school form a network of support for students and their families. Over time, parent support

groups from schools as well as national disease support groups such as SPARK (Society for the Promotion of ADHD Research and Knowledge) were included in meetings and conferences to help improve understanding and disseminate the work of the community teams and partners.

In summary, we have shown that for a community-based assessment and intervention program to work, it requires several steps: (i) an understanding of the prevalence of problems in the community, (ii) a unified agenda among different providers of care for youths such as education, social services and health, (iii) a calibrated pilot which can be scaled, and (iv) multisectoral and multidisciplinary integration with shared resources. The REACH program showed that a large scale national preventative and early intervention system can be implemented. REACH demonstrates a comprehensive approach to the early detection and treatment of childhood mental disorders in schools. However, as in other areas of the world, there is a pressing need for early identification and prevention programs even before school entry. The empirical base for mental health services is drawn largely from studies in the West, and there is a need for studies examining the determinants of risk and resilience within unique settings throughout the world.

Disclaimers

Acknowledgement

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The Transition from Psychiatric Hospitalization to Community Living: Local and Current Challenges

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ABSTRACT

While extensive efforts have been made in recent decades to enhance community mental health services around the world and in Israel, less attention has been given to the challenging transitional period from psychiatric hospitalization to community living. The current paper reviews the literature on discharge planning programs, which shows that using an interdisciplinary team and adapting a case management model to include overlapping relationships during the process of changing settings might lead to cost-effective outcomes. It is argued here that the current Israeli reform allows an opportunity to reconsider clients' needs and budget priorities, as doing so might lead to the development and implementation of appropriate discharge planning programs.

In Israel, public policy and legislation (1) reflect intensive and extensive efforts to promote recovery and community integration for persons with Serious Mental Illness (SMI), similar to the policy that exists in the United States (2). These efforts, which have focused on community mental health, resulted in a decline of psychiatric beds by approximately 50% between 2001 and 2011 (3) and the concurrent development, implementation and dissemination of various psychosocial interventions (4). However, despite the development of an impressive system to provide psychiatric rehabilitation services, and evidence of the effectiveness of the rehabilitation "basket of services" (4, 5), little attention has been given to the individual's transition from the hospital to the community.

The lack of a targeted intervention suited to the discharge phase indicates that specific challenges related to the transition from the hospital to the community are being overlooked. These challenges include the need to provide continuity of care, which would decrease rates of re-admission and promote community integration (6). The development and implementation of a discharge planning system that would create a bridge from hospital-living to community-living is crucial. Data have shown that while hospitalization durations have gone down in recent decades, rates of readmission have gone up (7, 8, see systematic review and full details in 9) and that persons with SMI do not feel sufficiently prepared for re-entry into the community upon discharge, and subsequently experience various unmet needs (10, 12). The current paper therefore views the new reform in mental health in Israel as an opportunity for creating a suitable discharge program. Accordingly, it reviews discharge programs that have been developed, implemented and studied in different countries, identifies their key elements, and suggests guidelines for adapting them to the local and current context of the reform.

THE ISRAELI CONTEXT: THE REFORM AS AN OPPORTUNITY FOR BUILDING BRIDGES

The reform that was recently instituted in the mental health system in Israel allows an opportunity for rethinking the needs of clients with SMI. The reform, launched in July 2015, transfers the responsibility for individuals' mental health care from the state to the health maintenance organizations. As a result, a single organization now bears responsibility for mental health care in both inpatient and community settings, leading to potentially greater cooperation between the various entities. Better coordination can also be expected with regard to the integration of physical and mental health care, as is often needed (13). In addition, the fact that the health maintenance organizations are now responsible for the provision of mental health care, both in hospitals and in community settings, might

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motivate them to minimize hospitalization days in order to lower costs. One key way to achieve this goal might be via appropriate discharge planning, which would likely reduce subsequent re-hospitalization. The Ministry of Health, which has taken on the role of regulation and planning (rather than being a service provider), could play a major role in the development of such discharge planning.

While it should be said that there is much debate with regard to the implications of the reform on quality and duration of treatment, stigma and additional issues, these matters are beyond the scope of the current paper. However, given that the reform has become part of the reality of mental health care in Israel, it is essential to look at this moment as an opportunity for the improvement of services. In the context of the hospital-to-community transition, ideas for improvement should be based on an exploration of the current discharge experience in Israel and also on an examination of discharge programs in other countries, which could potentially be adapted to the current and local emerging new conditions.

THE EXPERIENCE OF PSYCHIATRIC HOSPITALIZATION DISCHARGE IN ISRAEL

For many years concerns have been raised with regard to the discharge process in Israel. A project at Tirat Carmel Mental Health Center in Israel (11) that was described more than a decade ago, included a flexible intervention model of a transitional setting from hospital to community. The transitional setting was a hostel which provides temporary residence for persons who, upon release from the hospital, did not feel sufficiently prepared for direct re-entry into the community.

A recent survey in Israel addressed patient satisfaction among 835 persons who were discharged from psychiatric hospitals during the first half of 2015 (10). The survey showed that 63% of persons reported not being satisfied with the way the staff had prepared them for moving back into the community. The survey also showed that 66% reported that they knew what the next step in treatment was after discharge; 57% reported that their rehabilitation program was suited to their needs; 44% reported that the staff prepared them for discharge; and 39% reported that their social rights were explained to them. The results of this survey make it clear that the current situation is not satisfactory, and that there is a need for a formal systematic program to

accompany people with SMI as they move back into the community.

In addition, a recent qualitative study in Israel provided an analysis of interviews that were conducted with persons with schizophrenia with regard to their subjective experience of the transition from hospital to community (12). The analysis revealed that persons oscillated between feelings of vitality and strength, and feelings of despair and vulnerability. In addition, participants in this study reported that social, familial, employment and professional aspects were major factors that either enhanced or impeded their process of re-entering the community after hospitalization, dependent on the quality of provided support and involvement of significant others. Most importantly, the results highlighted the importance of supportive relationships and work as contributing to a successful transition (12). Not surprisingly, these factors are considered central to the various discharge programs reviewed below.

PSYCHIATRIC HOSPITALIZATION DISCHARGE: EXISTING PROGRAMS IN OTHER COUNTRIES THAT FOCUS ON PROVIDING CONTINUITY OF CARE

Beginning in the early 1980s, with the development and implementation of Assertive Community Treatment (ACT) model (14, 15) and additional psychiatric rehabilitation practices that occurred following deinstitutionalization (16), community integration became a major goal in mental health. In various places around the world, where the aim was to close psychiatric hospitals and replace them with community-based services, a focus on such services was evident (see Leff's studies on the TAPS project in England, 17; and a sociological review on deinstitutionalization in England, Italy and additional countries, 18). ACT marked a major turning point in the treatment of people with SMI as it provided an effective means for the enhancement of community integration (19). ACT has also addressed the "revolving door" phenomenon, which refers to the phenomenon of people with SMI being frequently hospitalized, and having only brief periods of time during which they are not hospitalized (20).

As a practice, ACT is not a clinical intervention but rather a system for organizing different services in the community for persons with SMI (21), requiring numerous resources, mental health authorities and the active support of the administration (22).

Critical elements of ACT include the application of a multidisciplinary team approach, integration of services, low client-staff ratios, a locus of contact in the community, medication management, a focus on everyday problems, quick replies to client emergencies, assertive outreach, individualized and time unlimited services. While it is true that ACT practitioners are involved in hospital admissions and discharges, as a way of promoting continuity of care (21, 22), their particular focus is on ongoing community services and not on the specific challenges that typify the transition from hospital to community.

Moving back into the community from a stay in a psychiatric hospital marks a unique period that includes both risks and opportunities. Studies have shown that the transition back into the community puts people with SMI at high risk for homelessness, violence, suicide and psychiatric re-hospitalization (23-26). These risks are more evident among persons who are young, single, male, have had previous hospitalizations, have a psychotic illness, have a poor support network, have a challenging social environment, display poor compliance, do not adhere to their follow-up plan, and were discharged from hospitalization too early (20, 27). It is important to point out that a delay in or lack of follow-up treatment has been shown to be related to poor outcomes and subsequent re-hospitalizations (20, 28), pinpointing the need for continuity of care (6). Providing such ongoing care might not only reduce the risk of psychiatric re-hospitalization and additional poor outcomes, but might also provide new opportunities for people with SMI as they re-enter the community setting (6, 12).

In their study on discharge planning, Jensen et al. (29) reviewed the origin of the concept of continuity of care. It was first conceptualized by Bachrach (30) as a dimension of care for persons with SMI which was assessed by examination of chart data. Joyce et al. (31) later reviewed the literature on continuity of care which revealed that the majority of reviewed papers conceptualized it from the perspective of the mental health worker. As a result, they argued for the need to include the patients' perceptions of continuity of care as well, and conducted a qualitative investigation based on both the literature on continuity of care (as reported primarily from the perspective of mental health workers) and on interviews with patients and family members. Their exploration resulted in the identification of themes that described the concept of continuity of care. These themes were service delivery, accessibility, relationship base and individualized care. Notably, the accounts of patients and family members corresponded to the descriptions of continuity of care in the literature (31).

First person accounts of care continuity correspond to a qualitative analysis of the literature (31), thus a complementary concept, namely "experienced continuity," was introduced in order to express the need to include the clients' perspective of the experience of continuity (32). With this in mind, most of the studies that assessed different programs of discharge planning examined continuity of care from both professionals' and clients' perspectives, as will now be detailed.

One comprehensive discharge planning program is the empirically tested clinical project in Canada, originally called the "Bridge on Discharge" and subsequently re-named as the "Transitional Relationship Model" (6, 33-36). This program was designed to assist individuals who had had prolonged psychiatric hospitalizations to successfully integrate back into the community, using a supportive constellation of interpersonal relationships (33-36). The program is therapeutic-relationship-oriented and uses a case management model that "transcends the traditional boundaries that separate hospital and community practice" (35). It emphasizes the need for an interdisciplinary team and overlapping relationships during the course of the move from one setting to the other, as well as the need to address peer and family relationships (35). Empirical evidence has shown that this program is cost-effective, as it saved 500,000$ (CAN) in one year, and improved participants' quality of life (pilot study N=38). Additional studies in Scotland and Canada have replicated the cost-effectiveness of the program (e.g., 34, 36).

Another model aimed at bridging the transition from hospital to community is the Longitudinally Based Discharge Planning and Treatment Model (LDPTM) (37, 38). This model is also oriented toward clients' needs, and it stresses a non-time limited and open-ended multidisciplinary and comprehensive program. As such, the program includes inpatient ward professionals, community mental health professionals and peers from the consumer group. The two key elements of the program are having peer support and overlapping services. In addition, a unique feature of this program is the feedback loop it provides, enabling clients to be readmitted to a crisis unit if necessary,

and then to proceed either back to the community or to the hospital. It is also based on case management models, as the hospital case manager assumes the role of discharge planner (37, 38). Unfortunately, although comprehensive and detailed information regarding this program is available, no studies have yet examined its effectiveness.

While the transitional relationship model and the LDPTM models stress a non-time limited discharge program, there is also evidence that a brief time-limited program is somewhat effective in creating a bridge from psychiatric hospitalization to the community setting. Dixon et al. (39) studied the effectiveness of a brief three-month critical time intervention (B-CTI) at discharge. In their study, they adapted the original nine-month critical time intervention to a three-month intervention. While the original nine-month program was found to be cost-effective and to reduce homelessness and negative symptoms (40, 41), the study on the brief version of the program at discharge showed that although this program did promote continuity of care (evident from both participant self-reports and from outpatient visits charts), there was a limited association between this continuity of care and overall patient outcomes (39).

Additional models also exist with a relatively less comprehensive description and less rigorous empirical support (e.g., Jensen et al. (29) used a single group evaluation strategy, and Price (42) used a qualitative oriented pilot study). Notably, the majority of the literature on this subject can be found in the fields of nursing and social work, although the need for a multidisciplinary team is emphasized. Nevertheless, upon an examination of the existing literature on discharge, and a review of the programs' descriptions and empirical support, it is clear that a formal systematic discharge plan is needed in order to enhance community integration and reduce psychiatric hospitalization re-admissions.

While continuity of care is crucial, it requires policymakers' support, funding and the cooperation of a variety of stakeholders. For example, the implementation of the transitional discharge model (previously called Bridge on Discharge) was followed by a discussion on the challenges in implementation and dissemination in both Canada and Scotland, summarized by Forchuk et al. (43). In Canada, the sustainability of the implementation and dissemination of the model was challenged as a result of its having only partial government support in Ontario, and funding that lasted for only three years. An

additional challenge was the limited staff understanding and commitment to the model, especially with respect to the coordination of peer support, which is a central aspect of the model. This problem was made even more complex by the general upheaval surrounding the period of divestment and change of ownership of provisional hospitals, leading to a lack of leadership. In Scotland, the challenges involved small piloting data, limited funding, and problems in adopting peer support as part of the model. As peer support is a key aspect of the program, concerns were raised with regard to various issues, including maintaining boundaries in these relationships, providing support for peer volunteers, and funding peer volunteers' activities and travel (43).

Deforge and Belcher (38), as well, discuss challenges to the implementation of discharge planning programs and make mention of governmental budget issues. They also stress that it is crucial for policymakers, staff and administrators to have a good understanding of the goals of the program. Interestingly, they call for a system reform that would provide resources to discharge planning programs. In addition, they mention clinical challenges that include high risk patients (e.g., those with a history of homelessness or violence) and the need to set priorities between staff members and clients, especially when there are co-morbid disorders (37, 38).

CONCLUSIONS

While extensive efforts have been made in recent decades to enhance community mental health services around the world and in Israel, less attention has been given to the challenging transitional period from psychiatric hospitalization to community living. Discharge planning programs that have been developed and implemented in different countries show that using an interdisciplinary team and adapting a case management model to include overlapping relationships during the process of changing settings might lead to cost-effective outcomes. It is argued here that the recent Israeli reform allows an opportunity to reconsider clients' needs and budget priorities, as doing so would hopefully lead to the development and implementation of appropriate discharge planning programs. Specifically, there are key elements in the reviewed discharge programs which should be incorporated into the contemporary Israeli context. These elements are: 1) overlapping relationships during the course of moving from setting to setting. This would include the adaptation of a case manage-

ment model to the transitional phase, meaning that the same professional would manage a patient's case from beginning to end, i.e., from the time of his/her stay in the hospital all the way through his/her integration back into the community; 2) an interdisciplinary team that would address the patient's social, familial and employment issues. The work of the team would be coordinated by a case manager and their collaborative work would start during the patient's hospitalization; 3) preparation of the family for patient's return, and ongoing communication with the family; 4) tailoring the program according to the person's needs and choices, using a shared decision model; 5) addressing peer relationships, as they provide much-needed support and social opportunities.

As emphasized above, preparing the field for the implementation of a discharge program is essential in order to have both a sufficient budget and commitment to the model by different stakeholders. All stakeholders would need to receive information with regard to expected cost-effectiveness and the key elements of the program. Preparing the ground in this way would hopefully lead to a high degree of loyalty, motivation and commitment to the program. Studies examining the process of implementation and assessing the effectiveness of the programs would also be needed in order to track the challenges and possible solutions to these challenges, in the process of creating a bridge from hospital to community.

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An Empirical Study of the Relationship Between Community Participation, Recovery, and Quality of Life of Individuals with Serious Mental Illnesses

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ABSTRACT

Background: Recovery and quality of life are key outcomes emphasized in mental health systems around the world. This study explores the extent to which efforts to facilitate community participation may enhance these outcomes.

Methods: Six hundred and six individuals with serious mental illnesses completed measures of participation, recovery and quality of life.

Results: Small, but statistically significant positive relationships between community participation and recovery and quality of life were found. Additional analyses identified specific participation areas that, if they are important and done sufficiently from the perspective of the respondent, resulted in higher levels of recovery and quality of life.

Limitations: Correlational analyses do not allow for causal explanations.

Conclusions: Results suggest that a greater emphasis on community participation, especially in specific areas that are important to the person and done sufficiently, may facilitate recovery and quality of life in community mental health systems. Implications and possible directions for policies and practices, especially within the context of Psychiatric Rehabilitation services, are offered.

INTRODUCTION

The facilitation of recovery and quality of life, rather than a focus on symptom stabilization and maintenance and reduced crises and hospitalizations, have become the goal of mental health systems around the world for individuals with serious mental illnesses. Nonetheless, despite almost two decades of recovery efforts in the United States and elsewhere, there is concern that recovery-oriented systems change remains embedded in traditional paradigms, despite the well-intentioned efforts of many (1). People with serious mental illnesses continue to be marginalized in society and often struggle to enjoy the benefits of full participation in community life.

Community integration is a distinct concept that has only been sporadically discussed in mental health policy and practice (2-4). Community integration has been more widely embraced in the broader disability community than in mental health systems and is rooted in deep philosophical and legal underpinnings. The concept emerged out of the "Normalization Movement" for persons with intellectual and developmental disabilities in Denmark in the 1950s and was expanded upon in the social role valorization framework espoused by Wolfensberger (5,6) that emphasized the creation of environments that enable all persons to engage in social roles valued by society. In the U.S., a powerful and persuasive disability rights movement successfully advocated for the Americans with Disabilities Act (7) that emphasizes community integration, including the requirement that governments "…give people with disabilities an equal opportunity to benefit from all programs, services, and activities (e.g., education, employment, voting, transportation, recreation, etc.)" (Title II). The 1999 ruling of the U.S. Supreme Court (8) ensured that the ADA applied to individuals with serious mental illnesses and resulted in the "Integration Regulation," which required that "services, programs, and activities must be delivered in a way that enables individuals with disabilities to interact with non-disabled people to the fullest extent possible (p. 3)" (9).

The result of this legislative act and judicial ruling has been the establishment of community integration as an

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inherent right for all people who experience disabilities, expanding their right to live, study, work, and recreate alongside and in the same manner as people without disabilities (10). From these previous rights frameworks and legislative and judicial acts emerges a definition of community integration as "the opportunity to live in the community, and be valued for one's uniquenesses and abilities, like everyone else (p. 1)" (11). The opportunities emerging from community integration policies, programs, and practices have been hypothesized to result in enhanced community participation (e.g., work, leisure, social participation) that ultimately facilitates greater levels of well-being and recovery (11). This community integration framework also suggests that the relationship is multidirectional where opportunities for participation increase well-being and recovery and increased well-being and recovery influence participation.

Recovery is defined in many sources as a process and an individual journey that involves the rekindling of hope and the support of others; belief in one's self and self-determination; and finding meaning and purpose in one's life through participation in valued roles in the community (12). These ideas mesh with Anthony's commonly cited definition of recovery as living a satisfying and fulfilling life (13). Recovery and well-being are intricately linked as well-being has been described as one's appraisal of their quality of life including satisfaction and the presence of positive moods (14). Community participation is the empowered, self-determined choice and action that individuals make to be active in valued roles in the communities of their choice, across a variety of domains in their life. Participation is seen as the active embodiment of the definitions that one has for well-being and recovery for their life. Individuals live a satisfying and fulfilling life through their participation.

There are numerous longstanding examples demonstrating a relationship between participation and constructs related to recovery and wellbeing. For example, research has shown that individuals with serious mental illnesses who are employed have higher levels of socialization, self-esteem, and ability to manage symptoms; lower levels of psychiatric symptoms and better global functioning; increased meaning in and higher quality of life compared to their non-working peers (15-19). Those engaged in educational pursuits have higher rates of employment, and increases in self-esteem, empowerment and meaning in life, as well as decreased hospitalizations (20-22). More friendships, especially close friendships, are associated with greater quality of life and ability to

cope with life stressors, and general life satisfaction, while marital status is also associated with higher general life satisfaction (23-25). Further, research finds that religious participation and spirituality support psychological wellbeing and can inhibit symptoms related to mental illness, increase feelings of empowerment and social inclusion, and provide a sense of hope and meaning and purpose in life (26-28). Women with a serious mental illness report numerous benefits of having children and being a parent (29), and the benefits of increased physical activity included higher quality of life and well-being and a reduction of mental health symptoms (30). While correlational – one cannot randomly assign someone to work, marriage, etc. – these consistent results are highly suggestive of a relationship between participation and various positive outcomes.

Recent research has also found some evidence in favor of this framework (31). Using data from 1,800 people enrolled in the Consumer-Operated Services Program, a multisite study of the effectiveness of consumer-operated programs conducted in the U.S. between 1998-2003, these authors found that three participation areas, civic engagement, friendship and spirituality, were associated with recovery, quality of life and meaning in life, and being a member of a group or in an intimate relationship predicted recovery and quality of life. Employment was only predictive of quality of life. This study had some limitations, however. The indicators of community participation were taken from various measures rather than a single instrument in the data collection protocol. Community participation was assessed as a dichotomous (i.e., participated or did not participate) rather than as a continuous variable assessing the extent of participation. Finally, the breadth of participation areas assessed was limited.

The proposed study further explores the relationship between community participation, recovery and quality of life, using a new dataset of more than 600 individuals where community participation was assessed using the Temple University Community Participation measure. This is an important step in this area of inquiry, connecting a broad range of existing literature across a host of participation domains (identified above) within the larger context of the community integration framework. Demonstrating a relationship between community participation based on individual choice and self-direction with recovery and quality of life indicators could have implications for future program and policy decisions that lead to the development of supports that truly meet the

expressed hopes, dreams and desires of participants.

This measure was specifically constructed to assess the extent to which respondents participate in a broad-range of areas, whether each area of participation is important to them, and the degree to which they felt their participation was sufficient. The breadth of this measure also allows us to utilize an empirically-derived multidimensional framework of participation that identifies three dimensions: productive, social and leisure participation (32) in our analyses. These three dimensions, proposed in Chang and Coster (33), are based on the World Health Organization's International Classification of Functioning, Disability and Health (ICF), and provide a clear definition of the content areas of participation. The specific hypotheses under test are:

1. There will be a positive relationship between recovery and quality of life and total number of participation days across all domains (i.e., intensity of participation), as well as total number of participation areas (i.e., breadth of participation).

2. There will be a positive relationship between recovery and quality of life and participation days in each of the productive, social and leisure participation dimensions.

3. Respondents who report that their participation was sufficient in each area that they also indicated was important to them will have higher recovery and quality of life scores than those individuals with insufficient participation in areas identified as important.

METHODS

DATA

A data set involving 632 individuals was created by appending data from individuals with mental illnesses who participated in six research studies conducted by the investigators between 2008 and 2013. The individuals in these studies were all over the age of 18, had a primary diagnosis (clinician or self-reported diagnoses) of schizophrenia-spectrum (DSM 295.xx) or major affective disorder (DSM 296.xx), and were fluent in English. The specific studies, and samples, were as follows: 1) Participants from two community mental health centers were recruited to assess the test-retest reliability of the Temple University Community Participation measure (TUCP) (N=119; baseline data); 2) Participants from two different community mental health centers were recruited to assess the inter-method reliability of the TUCP (N=120; baseline data); 3) Individuals who had been incarcerated

in the Philadelphia jail system for a study examining community participation needs and supports obtained (N=42; six-months post-release data); 4) Individuals recruited from two community mental health centers for a randomized, controlled trial examining the effectiveness of supports provided by a Center for Independent Living (CIL) (N=100; baseline data); 5) Mothers with a serious mental illness recruited throughout the U.S. primarily from Internet study posting who had primary or shared custody and were serving as the caretaker of at least one child second intervention to participate in a randomized, controlled trial to examine the effectiveness of an online, parent support intervention (N=131; baseline data); and 6) Individuals with serious mental illnesses who received public mental health services and were in the 50%-90% in terms of expenditures for mental health services in a county in Southeastern Pennsylvania (U.S.A.) for a randomized, controlled trial of the effectiveness of a self-directed care intervention (N=120; baseline data).

Out of the 632, data from 10 individuals were excluded because they had missing data for the TUCP measure and an additional 16 individuals were excluded because they reported a highly extreme amount of participation on the measure (i.e., greater than 500 participation days) which was viewed as unlikely to be reliable because it would indicate that they engaged in each activity an average of twenty days. Instead, we believe that these responses were evidence of acquiescence whereby they provided the same response (e.g., wrote down "25" or "30") across all 26 domains without reflection. Therefore, the final sample for the study was 606 participants. Each of the studies received approval from the Institutional Review Board of the authors' academic institution and, where necessary, the Institutional Review Board of the local municipality.

MEASURES

Temple University Community Participation (TUCP) measure. TUCP (34) queries respondents about the number of days of participation in the past 30 days in 26 areas without a staff person going with them. The measure also inquires about the importance of each participation area (yes/no) and the perceived sufficiency of participation in each area (enough, not enough, too much). TUCP has good test-retest and inter-method reliability (34,35) and in the current study the Cronbach's alpha is 0.72. Several scales were calculated for this study:

- Total number of participation days, calculated as the sum of participation days across all 26 items. Possible

scores on this construct range between 0 and 780 (30 days x 26 participation areas).

- Total number of participation areas with at least one day of participation in the past 30 days. Because the number of different participation areas included in the measure is 26, the possible scores on this construct range between 0 and 26.

- Number of participation days in social, productive, and leisure areas, based on the framework outlined in Chang et al. (32). Items in each domain are as follows: Social participation (going to or participating in civic or political activities or organizations; going to a social group in the community; getting together in the community or attending an event with family or friends; going to a community fair, community event or activity; and entertaining family or friends at home or visiting family or friends; scores range between 0 and 150); Productive participation (going to school to earn a degree or certificate; taking a class for leisure or life skills; working for pay; and participating in volunteer activities; scores range between 0 and 120); Leisure participation (going to a zoo, botanical garden, or museum; going to a gym, going to a theater or cultural event; going to a movie; going to a library; going to watch a sport event; going to a church, synagogue or place of worship; going to a park or recreating center; going to a barber shop, beauty salon, nail salon, or spa; and going to a restaurant or coffee shop; scores range between 0 and 300).

Recovery Assessment Scale (RAS). The perceived recovery from mental illness was measured with the 20-item version of the Recovery Assessment Scale (RAS) that is based on a factor analysis reported by Corrigan et al. (36). The items on the scale assess life goals and purpose, general outlook and attitudes, hope, not being dominated by symptoms, and asking for help. Each of the 20 items is rated on a five-point Likert scale (1 = strongly disagree; 5 = strongly agree). A composite RAS score ranges from 20 to 100 and is calculated by summing the 20 constituent items. Higher scores correspond to greater recovery. A comprehensive review of psychometric findings has found the RAS to have strong evidence of reliability and validity, including use by researchers in Israel (37). In the current study, the Cronbach's alpha for the RAS is 0.89.

Quality of Life (QOL) Interview. The 10-item Lehman's Quality of Life (QOL) measure is adapted from a longer interview used to assess how individuals felt about various aspects of their lives (38). This instrument was developed specifically for individuals with serious mental illness, with the possible answers to each of the 10 items on the scale ranging from 1 (terrible) to 7 (delighted). The composite score was calculated by averaging the scores on all the items, with higher scores indicative of greater overall quality of life. The Lehman QOL questionnaire has demonstrated good validity and reliability (38). In the current study, the Cronbach's alpha for the QOL is 0.83.

Demographics. Each of the studies also included information on a number of demographic characteristics, including gender, age, race and ethnicity, marital and relationship status, presence of children, education, and indicators of whether the individual was living independently (defined as living alone in his or her own apartment or home, in a shared apartment with family members, or in a shared apartment with roommates) and whether the individual had ever been homeless.

ANALYSES

To test the first hypothesis, we computed Pearson correlations to examine the association between RAS and QOL and the number of participation days and the number of participation areas. Pearson correlations were also used to examine whether there were significant positive associations between RAS and QOL and the number of participation days in social, productive and leisure areas (hypothesis 2). For these analyses, the tests for the difference between two dependent correlations were conducted using the method suggested by Steiger (39). The tests were run with the applet for comparing overlapping correlations from a single sample on the Simple Interactive Statistical Analysis (SISA) website (http://www.quantitativeskills.com/sisa/statistics/corrhlp.htm). To test the third hypothesis, a series of independent samples t-tests was run to compare average QOL and RAS scores for those individuals who found each participation area important and participated in it enough, and those who found each participation area important and participated in it less than enough.

RESULTS

SAMPLE DESCRIPTION

Of the 606 individuals in the final sample, 209 (34.5%) were male, 396 (65.3%) were female, and 1 (0.2%) was transgender. Two hundred and twelve (35.6%) indicated they were white, 356 (60.7%) were black, 8 (1.4%) were Asian, 36 (6.2%) were Native American, 5 (0.9%) were

Native Hawaiian or Pacific Islanders, and 21 (3.6%) chose their race to be "other." Twenty-six (4.5%) said they were of Latino or Hispanic ethnicity. The average age of the sample was 44.8 years (s.d. = 10.3). Two hundred and sixty-nine (44.5%) were married, in a domestic partnership, or had a significant other. Just over two-thirds of the sample (67.5%) had natural, adopted, or stepchildren. One hundred and fifty-eight (26.1%) had not completed high school, 204 (33.7%) had a high school diploma or a GED, and 244 (40.3%) had more than a high school education. Three hundred and ninety-eight (70.1%) of the individuals in the sample were living independently, and 326 (54.1%) had been homeless at one point in their lives.

The average number of participation days for the sample was 71.9 (s.d. = 51.8), and the average number of different areas in which individuals participated at least once was 9.3 (s.d. = 4.5). The mean number of participation days in social areas was 8.2 (s.d. = 11.2), productive areas was 8.2 (s.d., = 11.5), and in leisure areas was 16.6 (s.d. = 18.8). The total number of participation areas considered important by respondents was 17.4 (s.d. = 5.7) and the total number of participation areas considered important with at least one day of participation was 8.5 (s.d. = 4.4). On average across respondents, 51.6% (s.d. = 23.8%) of the participation areas that they considered to be important had at least one day of participation. The average RAS and QOL scores were 78.1 (s.d. = 10.6), and 4.5 (s.d. = 1.0), respectively. The Pearson correlation between RAS and QOL measures in this sample was r (d.f.=601) = 0.55, p < 0.0001. The correlation suggests some overlap on the measures, but also a fair degree of distinctiveness.

Relationship Between Participation Days and Areas and Recovery and Quality of Life (Hypothesis 1)

The correlations between the total number of participation days and RAS and QOL were r(602) = 0.24, p < 0.0001 and r(601) = 0.17, p < 0.0001, respectively. The difference between these correlations was not statistically significant (difference = 0.07, Steiger's z = 1.85, two-sided p-value = 0.064). The respective correlations between the total number of participation areas the respondents engaged in and RAS and QOL were r = 0.27(602), p < 0.0001 and r (601) = 0.26, p < 0.0001. Again, the difference between these correlations was not statistically significant (difference = 0.01, z = 0.27, p = 0.79).

Relationship Between Participation Domains and Recovery and Quality of Life (Hypothesis 2)

The correlation between RAS and the number of participation days in social areas was r(602) = 0.23, p <

0.0001, which was significantly higher than the correlation between RAS and the number of participation days in productive areas (r(602) = 0.12, p < 0.0027; difference = 0.11, z = 2.90, p = 0.0038) but not significantly higher than the correlation between RAS and the number of participation days in leisure areas (r(602) = 0.18, p < 0.0001; difference = 0.05, z = 1.33, p = 0.185). Similarly, the correlation between QOL and the number of participation days in social areas was r(601) = 0.19, p < 0.0001 was significantly higher than the correlation between QOL and the number of participation days in productive areas (r(601) = 0.11, p < 0.0057; difference = 0.08, z = 2.10, p = 0.362), but not significantly higher than the correlation between QOL and the number of participation days in leisure areas (r(601) = 0.14, p < 0.0006; difference = 0.05, z = 1.31, p = 0.1892).

Sufficient Participation in Important Areas and Recovery and Quality of Life (Hypothesis 3)

T-tests comparing the average RAS and QOL scores for individuals who had sufficient versus insufficient participation in each participation area that is important to them are presented in Table 1. The results show that those who reported sufficient participation in each area that was important to them had significantly higher QOL scores than those who did not have sufficient participation in all 26 participation areas. A more mixed set of findings was found on the RAS. Specifically, no differences between the groups based on sufficiency were found in the following areas: going shopping; going to a library; going to watch a sports event; going to a gym; going to a barber shop, beauty salon, nail salon or spa; going to a 12-step group for substance use problems; going to another type of support group; working for pay; going to school to earn a degree or certificate; and going to or participating in civic or political activities or organizations.

DISCUSSION

Overall, the results from this study offer some support for each of the three hypotheses and the overarching hypothesis that community participation contributes to individuals' recovery and quality of life. First, we found a modest but statistically significant association between overall days of participation (i.e., intensity of participation) and levels of recovery and quality of life. Engagement in a broader range of participation areas (e.g., breadth of participation) was also found to be associated with higher levels of recovery and quality of life.

Second, in an attempt to delve into the types of partici-

Table 1. *T-tests comparing the average RAS and QOL scores for individuals who had sufficient and insufficient participation in each of the important participation areas.*

		Important & Not Done Enough			Important & Done Enough			T-Test		
TUCP Item		N	Mean	S.D.	N	Mean	S.D.	t-Value	DF	P-Value
1. Go shopping at grocery store?										
	RAS	157	77.48	10.15	326	78.70	10.70	-1.22	323.1	0.2243
	QOL	157	4.26	1.06	326	4.61	0.94	-3.52	279.2	0.0005
2. Go to a restaurant or coffee shop?										
	RAS	192	76.32	10.61	201	80.69	9.25	-4.34	378.5	<.0001
	QOL	192	4.11	0.99	201	4.87	0.85	-8.13	377.2	<.0001
3. Go to a church, synagogue, or place of worship?										
	RAS	316	78.43	10.25	151	80.51	8.98	-2.24	333.4	0.026
	QOL	316	4.44	0.98	151	4.71	0.92	-2.82	311.7	0.0051
4. Go to a movie?										
	RAS	263	77.68	10.85	82	81.46	8.00	-3.42	182.1	0.0008
	QOL	263	4.37	1.07	82	4.93	0.79	-5.17	180.7	<.0001
5. Go to a park or recreation center?										
	RAS	289	77.50	10.74	142	80.28	9.84	-2.67	303.5	0.0079
	QOL	289	4.35	1.03	142	4.78	0.91	-4.49	312.7	<.0001
6. Go to a theater of cultural event?										
	RAS	291	77.97	10.31	77	81.00	10.16	-2.32	120.7	0.0219
	QOL	291	4.40	1.01	77	4.82	0.84	-3.77	139.7	0.0002
7. Go to a zoo, botanical garden, or museum?										
	RAS	304	77.74	10.97	56	79.95	9.31	-1.58	85.72	0.117
	QOL	304	4.32	1.02	56	4.91	0.93	-4.3	81.38	<.0001
8. Go to run errands?										
	RAS	107	77.11	11.86	318	79.68	9.40	-2.04	153.3	0.0434
	QOL	107	4.17	1.20	318	4.72	0.87	-4.34	144.8	<.0001
9. Go to a library?										
	RAS	287	78.19	10.60	129	79.64	10.05	-1.33	259	0.1832
	QOL	287	4.41	0.99	129	4.64	0.93	-2.27	261.6	0.0242
10. Go to watch a sports event?										
	RAS	192	77.88	10.83	78	79.28	9.73	-1.03	157.9	0.304
	QOL	192	4.31	1.06	78	4.77	0.88	-3.59	170.2	0.0004
11. Go to a gym?										
	RAS	361	77.89	10.88	80	80.01	8.47	-1.91	143.1	0.0583
	QOL	361	4.39	0.96	80	4.81	0.93	-3.62	119.1	0.0004
12. Go to a barber shop, beauty salon, nail salon, spa?										
	RAS	272	77.55	10.50	179	79.45	10.21	-1.92	388.4	0.0562
	QOL	272	4.33	1.02	179	4.68	0.89	-3.95	416	<.0001
13. Use public transportation?										
	RAS	86	76.92	10.00	254	79.57	10.16	-2.12	148.8	0.0359
	QOL	86	4.28	1.13	254	4.66	0.97	-2.74	130.3	0.0069

TUCP Item		Important & Not Done Enough			Important & Done Enough			T-Test		
		N	Mean	S.D.	N	Mean	S.D.	t-Value	DF	P-Value
14. Go to a 12-step group for mental health issues?										
	RAS	186	76.75	10.13	180	79.36	10.00	-2.48	363.8	0.0137
	QOL	186	4.21	0.98	180	4.72	0.92	-5.12	363.7	<.0001
15. Go to a 12-step group for substance use problems?										
	RAS	129	78.70	9.58	127	79.13	9.79	-0.36	253.6	0.7215
	QOL	129	4.41	0.92	127	4.64	0.91	-2.01	254	0.0454
16. Go to another type of support group?										
	RAS	150	78.10	9.78	112	79.81	10.51	-1.34	229.5	0.1802
	QOL	150	4.31	0.96	112	4.78	0.98	-3.84	236.3	0.0002
17. Go to a consumer-run organization?										
	RAS	168	76.69	9.98	166	80.63	9.74	-3.65	332	0.0003
	QOL	168	4.23	0.98	166	4.72	0.93	-4.64	331.5	<.0001
18. Go to a social group in the community?										
	RAS	219	77.71	11.30	107	80.27	9.55	-2.14	244.9	0.0333
	QOL	219	4.30	1.02	107	4.78	0.87	-4.41	243.4	<.0001
19. Work for pay?										
	RAS	296	77.91	10.96	140	78.73	11.02	-0.73	271.5	0.4687
	QOL	296	4.30	1.00	140	4.71	0.96	-4.12	283.7	<.0001
20. Go to school to earn a degree or certificate?										
	RAS	297	78.08	10.72	116	80.10	9.32	-1.89	239.7	0.0596
	QOL	297	4.33	0.99	116	4.67	0.91	-3.27	226.1	0.0012
21. Take a class for leisure or life skills?										
	RAS	300	77.83	10.83	76	81.34	8.62	-3	141.3	0.0032
	QOL	300	4.27	0.95	76	4.92	0.98	-5.24	113.5	<.0001
22. Participate in volunteer activities?										
	RAS	278	77.38	11.06	154	80.36	9.61	-2.92	354.5	0.0037
	QOL	278	4.35	1.01	154	4.77	0.82	-4.7	372	<.0001
23. Get together in the community or attend an event with family or friends?										
	RAS	259	77.12	10.46	192	79.95	9.59	-2.98	429.3	0.0031
	QOL	259	4.31	1.03	192	4.73	0.86	-4.77	442.8	<.0001
24. Entertain family or friends in your home or visit family or friends?										
	RAS	255	76.53	11.24	238	80.42	9.36	-4.19	484.8	<.0001
	QOL	255	4.23	1.03	238	4.80	0.84	-6.72	482.1	<.0001
25. Go to a community fair, community event or activity?										
	RAS	229	78.15	10.57	116	80.55	9.74	-2.1	248.4	0.0367
	QOL	229	4.32	1.01	116	4.81	0.88	-4.66	261.6	<.0001
26. Go to or participate in civic or political activities or organizations?										
	RAS	177	78.53	9.51	98	80.57	10.68	-1.58	181.6	0.1169
	QOL	177	4.34	0.91	98	4.72	0.97	-3.2	189.6	0.0016

pation that might be most meaningful we gauged whether different domains of participation contributed more or less to recovery and quality of life. Higher amounts of productive, social and leisure participation all had small, but statistically significant positive relationships with recovery and quality of life. Social participation had the highest correlations in both areas. Surprisingly, the correlations between recovery, quality of life and participation in productive activities, such as working, going to school, or volunteering, was the lowest of the three areas. This finding may simply reflect that both the RAS and the Lehman Quality of Life Interview may lean more heavily on social participation constructs than productivity constructs, thereby accounting for the higher scores. For example, eight of the ten items on the QOL measure pertain to leisure and social factors. The RAS also contains factors that emphasize social relationships. As can be seen in Table 1 by looking at the total number of individuals in each participation area who indicated that the area was important to them, the productive participation areas are among the most important areas to our sample, making this finding worthy of additional exploration.

Third, the results presented in Table 1 offer a number of interesting findings. By adding together the total N's for both groups it can be concluded that every participation area was rated as important by at least 50% of the respondents except for watching sports, participating in a civic or political group, or attending 12-step groups. Moreover, more than 50% indicated that their participation was insufficient in all areas except four: going shopping at a grocery store, going to a restaurant or coffee shop, running errands, and using public transportation. In some areas the extent of insufficient participation was approximately 80%, such as going to a gym, going to a movie, or taking a class for leisure or life skills. Overall, it is clear that the broad-spectrum of participation areas that are being measured are important to people with serious mental illnesses and they are generally not participating in these area to the degree that they would like to.

It was hypothesized that insufficient participation in each area would be associated with lower levels of recovery and quality of life. Such a relationship was found between all 26 participation areas and our measure of quality of life, and most of these were highly statistically significant (e.g., p<.001). It appears that sufficient participation in areas important to individuals may facilitate quality of life. A statistically significant relationship at p<.05 was only found in 15 out of the 26 participation areas and

the measure of recovery. The participation areas where a relationship between sufficiency and recovery was found included those where a clear connection could be made to hope and asking for help, including going to a church, synagogue, or place of worship, going to a 12-step group for mental health issues or joining a consumer-run organization, as well as social participation, such as going to a movie, a park and recreation center, theater or cultural activity, or a social group in the community. Areas such as shopping, going to the library, watching a sporting event, going to a gym or barbershop were some of the areas where there was not a relationship between sufficiently participating and recovery. It is plausible that these types of participation may be too mundane (e.g., shopping), infrequent (e.g., going to the library), or not important enough (e.g., watching a sporting event) to impact one's recovery. But it is not clear why perceived sufficiency in other key areas that bring purpose and meaning in people's lives, such as working for pay, going to school to earn a certificate or degree, or participating in civic or political activities or organizations, are not related to recovery. One possible explanation may be that individuals may have such low expectations for participation in these areas that any participation, even one or two days, may be viewed as sufficient and enhance quality of life, but may not be enough to affect recovery.

The findings from this study have a number of implications for community mental health service providers as they continue their efforts to create recovery-oriented systems. Our results suggest that more community participation is associated with greater levels of quality of life and recovery, especially when it is in areas that are important to individuals and done to the extent that people desire. One basic implication is that greater attention should be paid to measuring community participation of individuals with serious mental illnesses to obtain a better picture of the areas of greatest interest for participation and where there is the greatest gap in terms of sufficiency of participation from the consumers' perspective.

With the inclusion of community participation assessments as a standard component of mental health services, the need for interventions to support increased community participation will become clear. For example, to date, evidence-based practices have been developed to promote participation in areas such as housing, employment, and education, but less attention has been paid to developing interventions to enhance participation in other areas that are important to people, especially leisure and recreational participation and religious/spiritual partici-

pation. Interventions to support more robust community participation could utilize the "supports technologies" that have proven successful in increasing competitive employment outcomes (Supported Employment) (40-45), educational achievements (Supported Education) (46,47), and independent housing (Supported Housing) (48,49). Each of these intervention models share these features: 1) supports begin as soon as an individual expresses interest in greater participation in a particular area; 2) placement – into competitive jobs, mainstream educational programs, or non-congregate independent housing, for example – is rapidly achieved, with no readiness requirements or pre-placement training or preparation; 3) each individual is given a choice, and options, with regard to what they do and where they do it; 4) participation occurs in normalized settings with similar expectations as anyone else engaged in that activity; 5) supports occur in community settings rather than in separate mental health facilities; 6) supports are offered as long as they are needed and desired to sustain participation; and 7) supports are integrated into other services to the degree desired by the individual. Care must be taken to develop services and supports that promote increased opportunities for individual service users to participate more robustly in the larger community to maximize opportunities for interacting with those who do not experience disabilities rather than participation that occurs in segregated settings. Moreover, these interventions should facilitate self-determination and choice for participation in areas that are important to the individual, rather than that which is most expedient for programs or providers, and that is done to the extent desired by the person.

A major limitation of this study is that it is correlational and caution must be taken not to assume causality. That is, recovery and quality of life could facilitate community participation as much as community participation may facilitate recovery and quality of life. Further research is needed to tease out the direction of the relationship. Moreover, while the relationships are statistically significant and consistent, they are relatively small. There is clearly more to facilitating recovery and quality of life than community participation. Nonetheless, the enhanced opportunities for community participation that would be brought about by the adoption of a community integration framework may represent the second-order change, or transformative change, that is necessary to achieve the creation of robust, recovery-oriented mental health systems around the world (1).

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Training Arab Practitioners in Culturally Sensitive Mental Health Community Interventions

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ABSTRACT

The present paper describes an innovative initiative aimed to facilitate Arab MA students to develop integrated cultural competencies and act to promote mental health within the Israeli Arab community. In order to achieve this goal the initiative took the form of an Arabic language seminar that strove to bind the students' familiarity with Arab culture with reading materials and research literature on mental health issues and practices from the Arab world. We describe the need, development, processes and the outcome projects of the seminar. The academic setting is described as a nourishing and facilitating environment for training and preparing future community leaders who will bring about social change in mental health issues.

INTRODUCTION

Community mental health is a body of knowledge and practice in which individuals' wellbeing and resilience is believed to be mutually influenced by the community's resources and its strength. Researchers and practitioners in this area study how social norms and values affect mental health issues and how, by collaborating with key figures and organizations in the community, these norms can be modified and adapted to the needs of those who cope with psychiatric disorders. Practitioners in community mental health seek debilitated populations in which psychiatric disorders are more likely to appear, and look for ways to empower individuals with these disorders and enhance their social integration. One of these populations is the minority group of Israeli Arabs who experience a transition from a traditional and collectivistic society into a modern and an individualistic one. In this paper we describe a special innovative initiative with MA Arab students to train them as culturally sensitive social agents by learning how to bind their familiarity with local Arab culture with their growing knowledge of community mental health concepts and practices.

We will begin by describing the mission of training practitioners in culturally sensitive mental health community interventions by integrating the social norms and cultural attitude and community mental health concepts and strategies. We will further depict the training process of Arab students participating in the seminar taught in Arabic at Haifa University, their challenges and achievements and the developmental process they experience in this seminar.

Culture refers to characteristics that people share such as language, race, religion, ethnicity disability, sexual orientation, and social class (1). Within a culture people often share beliefs, values, and typical ways of feeling, thinking, acting, and viewing the world (2). There is wide agreement regarding the importance of cultural competence in mental health to which the disparities in services are an important reminder. Lower rates of service access, gaps in assessment and diagnosis and discrepancies in treatment recommendations for consumers from different cultures are well documented.

Israel is a multicultural and pluralistic society comprised of two major ethno-national groups, Israeli Jews and Israeli Arabs who differ in many aspects (3, 4), including their religion, cultural values and social constructs (5). Religion differentiates Israeli Jews and Israeli Arabs whose religions are Islam, Christianity and Druze. Concerning cultural values, Israeli Arabs are often referred to as a traditional collectivist culture while Israeli Jews have been described as a modern, individualistic and western culture (6-10). In terms of social constructs, Arab societies are often characterized by patriarchy, primary group relations with an emphasis on collective over the individual (6, 11) in contrast to Israeli Jews (10). With regard to mental health

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service utilization, data have consistently revealed large gaps, with much higher use among the Jewish population (12, 13). According to the Central Bureau of Statistics (CBS) (14), despite the Arabs comprising 20% of the population only 7% of those consuming psychiatric rehabilitation services in Israel are Arab.

The low use of mental health services among the Arab population is attributed to various reasons including lack of information and knowledge about services and access to them, language barriers, stigma and a preference for conventional religious treatment over traditional treatment (15).

Efforts to address some of these well documented and disturbing issues include helping non-Arab rehabilitation practitioners to acquire the important cultural competence (16). However, Arab practitioners who wish to be trained in providing community mental health services to Arab consumers must also acquire cultural competencies: They need to learn how to integrate their first hand knowledge of Arab culture and values with their growing understanding of community mental health concepts to provide effective services for the Israeli Arab population. They specifically need this training because they come to represent for these consumers the dominant majority's western ideology which is perceived as trying to influence and change traditional perspectives and values. To be successful in achieving integrated cultural competence, implementation needs to occur at multiple levels, including training and supervising practitioners and adopting policies and procedures at an organizational level to enhance an organizational culture that supports cultural diversity.

Training new practitioners in the area of culturally sensitive mental health requires that practitioners recognize contextual and systemic dynamics such as gender, age, socioeconomic status, culture/race/ethnicity, religion and provide appropriate individual and systemic interventions (17, 18). However, implementing these contextual and cultural concepts can be difficult, even among experienced therapists from the same culture (19). Simply knowing about cultural issues does not sufficiently qualify practitioners as culturally competent clinicians (20). What is needed is an experiential learning approach to acquiring a cultural and contextual awareness and integrating it with conceptual thinking (21, 22). Most training interventions address the issue of improving cultural competence of providers of one culture to work with consumers from other cultures and backgrounds (23-30). Few programs have focused on improving the skills of same culture mental health workers to improve services in their communities of origin (31, 32).

One report describes the training of indigenous mental health workers during the development of the Papago Psychology Service for Native Americans. Khan et al. (31) report several benefits to provide mental health workers with better skills to interact with their own communities and to improve their confidence to implement successful mental health interventions. As with other experiences, like the educational training program for Aboriginal and Torres Strait Islander Instructors (32), the training was felt to be empowering and provided information that was seen as highly relevant and important in assisting people with a mental illness in their communities. To address the important issue of providing training in integrated cultural competencies, the Department of Community Mental Health at Haifa University developed a seminar offered to Master Level Arabic speaking students focusing on training them to identify and respond to the Arab population's issues of people with Serious Mental Illness (SMI). In the next section we will describe the process of planning and carrying out this seminar followed by a brief presentation of a number of the students' fieldwork projects.

DESCRIPTION OF THE SEMINAR

The first stages of preparing for the seminar that has been presented now for three consecutive years were characterized by anxiety and hesitation, not least due to previous abortive attempts to promote mental health in the Arab sector. In the past it left all involved disappointed and disheartened, and left the field with the same needs that had generated the attempts in the first place: absence of experience in teaching the subject in Arabic, lack of agreed upon mental health terminology in the Arabic language and a mistaken notion that Arabic professional material does not exist or is inaccessible. On the other hand, there were motivating forces. Most important was the hope that an academic seminar of this kind would initiate a body of agents for social change in the sphere of mental health in Arab society. The Arab students themselves were perhaps the main impetus, after so often articulating their aspirations in so many diverse opportunities to do precisely this.

TARGET POPULATION

Each year the seminar had consisted of approximately eight Arabic speaking students pursuing an MA degree at the Department of Community Mental Health at Haifa University. The students represented the Arab Israeli sector in their heterogeneity: Muslims, Christians and Druze,

some from all-Arab villages and towns and others from mixed Jewish-Arab cities, some religious and some secular, with a few of the female students dressed in traditional religious attire including head-dress and others in western garments. Most of the students have had no prior experience in the application of the more recent rehabilitation and recovery theories and methods. Some were social workers or nurses while others were fresh graduates of the behavioral sciences, with little experience.

THE TRAINING PROCESS

The seminar, consisting of weekly classes throughout the entire year, covered the following three areas of knowledge:

The first was an overview of the attitudes and conceptions of Arab Israeli society pertaining to mental health consumers and families and common means of care within their specific social cultural context. So, for example, the students learned about the four sub-groups that comprise the Arab Israeli population with regard to the kind of mental health services most suitable for each. The religious Muslim population, both rural and urban, relate more comfortably to practitioners familiar with Islam and who themselves lead an observant traditional way of life, including modes of dress and speech. Secular, mainly urban Muslim culture is more accommodating towards care givers of both genders and services outside the immediate geographical vicinity. In the villages this sector is more conservative, with regard to the gender if not the religious observance of the service giver. The Christian group is by and large considered to be the most similar to the general Israeli secular public requiring no special modifications in the services available to the general population. Lastly, the Druze contain two distinct populations – the northern rural population and the two villages on Mount Carmel. The former are more traditional and conservative and resemble the rural Muslims discussed above, in terms of both the gender specifics of the preferred care giver and the geographical location of the services required.

The second area touched upon identifying needs and collecting data about the potential projects the students could undertake as part of the seminar requirements. For example, one female student chose to propose and pilot an outreach program to unemployed people with schizophrenia without prior affiliation to any rehabilitation or therapeutic agency. This student prepared an outline about the illness, available treatment and ways of making contact and establishing trust with the consumers and their families, available means for improving their standard of

living, and ways to deal with consumers and/or family members who show no desire to change the state of affairs. She was guided to create a plan to engage potentially helpful local resources such as family members or religious authorities. In addition, she was directed to address the praxis of the recovery oriented rehabilitation approach as it applies to the specific social cultural context.

The third area had to do with strategies for planning, developing and carrying out the projects and specifically communal ones focusing on location of the project to be established, to whom it is planned to serve, its immediate environmental conditions, dialogue and potential partnerships, communal services involved, governing principles and values and implementation strategies.

THE STAGES OF THE SEMINAR

The first stage began by processing students' worries and skepticism regarding their competencies to cope with the requirements of the seminar and open classroom discussions about the students' personal attitudes toward and conceptions of mental health difficulties and means of treating them. The atmosphere was accommodating and accepting, allowing room for the emotions that surfaced and stories from their personal and professional experience. Each story generated class discussions exploring students' personal attitudes and posing thought provoking questions. Sometimes terms such as recovery as compared to cure had to be redefined and normal functioning and ways to conceptualize and assess it were discussed.

The seminar in general and more specifically the development of the students' professional self-identity involved a quest for source material, and for methods of organizing and presenting it to their peers. Some students noted that independent learning in preparation for the presentations "increased a sense of commitment and responsibility," while others said that their newly acquired knowledge of mental health in general and knowledge relevant to Arab society in particular "enhanced self-confidence and a sense of mastery in preparation for bringing projects into effect," or that the coaching in class using simulation techniques of intakes with consumers or families was "particularly instructive and furnished them with a multitude of tools and proficiencies." Some noted that the open discussions and exploring of their personal attitudes "changed them and instilled in them optimism." In a feedback session towards the end of the semester most participants testified that by the midway point the seminar imbued them with a sense of competence. The few who found it hardest to

relinquish old attitudes were those for whom the new knowledge clashed too harshly with and was grasped as a threat to religious or personal values. For example, a female student for whom mental impairment was always a sign of religious slackness and the result of witchcraft, found the notion hard to accept that just like any other illness, the mental form has a biological and genetic basis. By extension, she maintained her belief in traditional religious interventions in preference to the conventional, "I see that they do not work," she said of the latter.

In the second stage, towards the end of the first semester students started to present their proposed projects. Often the student's own experience was the incentive behind the choice in preparation for the class lectures. For example, the two students who presented the topic of coping with mental illness in the Arab family decided to establish a support and empowerment group for wives of consumers in the village of Iksal near Nazareth. In other cases the choice of project emanated from prior knowledge and experience. So, for example, a student with a degree in special education chose to organize a group for improving interpersonal communications and promoting emotional expression for children with autism. Another chose as her project to translate a Ministry of Health Rehabilitation Basket (the benefits granted individuals recognized by national security as legitimate consumers of mental health services, in employment, housing, education and recreation) brochure from Hebrew to Arabic. Based on previous experience, she identified it as a vital tool for Arabic speaking consumers to access rehabilitation services and ease the task of Arabic speaking practitioners. The next step was to establish contact with communal services and functionaries that the projects required in order to consolidate viability.

Each proposal was discussed in class, and views and personal opinions pertaining to the rationale behind the choice were voiced. This contributed to the final shaping of the proposed projects and transforming them into viable plans of action. The ideas were studied in depth with reference to relevant bibliographical items, examination of the aim and projected contribution, mapping of the resources that would be required for implementation – including body of knowledge, tools and proficiencies, identifying the local people who could promote and support the attempt as well as those who may hinder and oppose it, the tools for successful handling of the obstacles, and finally - standards for evaluating the project's outcomes. Besides studying the theoretical aspects of their projects, and in order to furnish the students with experience of the

challenges they were about to face, seminar participants performed simulations of anticipated encounters on the path to full implementation of their projects. After each simulation tutorial a conclusion drawing session was held and the experience was processed in class to glean from it new tools for intervention. During the discussion it was clarified that the learning process the seminar participants were undergoing throughout the planning and implementation of the project was quite as important as its anticipated results.

The academic process involved in the theoretical preparatory study of the project had a distinct emotional angle which was constantly present in the questions that the students brought to class. This angle was handled through sessions of reflective learning aimed to help the students cope with the emotional evocation of the challenge before them. For example, how does one begin an intake with a consumer with schizophrenia who barely speaks and has hardly left his house for years; how does one respond to the family's frustration with the services' laxity toward a family member and how does one encourage a consumer to consider going to therapy for the first time in his or her life. In the course of one of these sessions, two of the students shared a disturbing experience they had with a social worker whom they had approached for help in making contact with two families of consumers. She voiced her opinion – without ever meeting them – that they were not up to the task. Early encounters with consumers, families and local service providers were rife with such emotionally disturbing events. They were brought up by the students or the facilitator and processed through simulation. By repeating the experience in class the students could review events calmly, accumulate relevant knowledge and competence but mainly restore their self-confidence and sense of competence.

The final two sessions of the first semester were devoted to reflective feedback by the participants concerning the personal process they had undergone, and – because it sometimes occurred during the break – to a final emotional, practical and mental preparation for the plunge into actual work. To complete the semester projects were submitted for the facilitator's review and, where necessary, revision. They detailed the underlying idea, rationale, target population, stages of development and planning, requisite resources, implementation plans and standards for evaluation of the outcomes.

In the third stage, during the second semester students began to implement their projects which was a significant turning point, as one described "transition from the theo-

retical to the stage of real doing is extremely satisfying," or as described by another, "you begin to feel like a mental health professional with a clearer, better defined conception, based on a stalwart body of knowledge and equipped with methods, tools and competencies that provide a sense of control, even if the end of the road is still away on the horizon." Obviously, not all anxieties were entirely allayed. At this stage the facilitator himself was slightly perturbed, especially in anticipation of the fledglings' "maiden flight."

In view of the deep rooted attitudes – of community, extended family, local practitioners – pertaining to mental health that they were about to tackle, it was clear that what the seminar participants would need more than anything was that the facilitator would accompany the novice practitioner for immediate guidance and support. Some of the study sessions were duly transferred into the field, to the local agency implementing the project, or to accompany a student on an especially difficult mission, such as a house call for a first encounter with a consumer with difficulties in verbal communication, or with a local social services functionary trying to avoid the meeting: "because she dreads involvement in mental health issues with which she is unacquainted and therefore fears." This was quite a common reaction even if all the local service person was asked to do was to help put the student in touch with families in her jurisdiction. Sometimes the facilitator accompanied the novice practitioner to housebound consumers whose families objected to intervention, fearing that the consumer's condition would deteriorate as a result. The sessions that were held in class at this stage were devoted to updates on progress made in the field with feedback from the facilitator, and to investigation, processing and responding to difficulties encountered vis-a-vis the consumers, their families and service providers or others in the community. The students' professional credo took shape during this phase, their humanity and professional competence refined. Empowerment of the novice practitioner is a prerequisite for the empowerment of consumers and local services.

The entire process found conclusive expression through the final seminar papers describing the projects. Those were comprised of an introduction to what inspired the project (original, innovative, ground breaking, meeting a real previously unanswered need), background, target population and the rationale based on data and professional bibliography. It also included an outline of existing material relevant to the specific project, description of the stages of planning and establishing the project, standard evaluation tools, partnership and dialogue with the target population and community functionaries, trouble shooting methods, implementation and/or attempts thereof. The final papers ended with a factual update and a personal reflective one with individual insights and deductions concerning the entire undertaking.

A SAMPLE OF STUDENTS' PROJECTS

Project one: Glossary for mental health terminology in Arabic

The rationale behind the original decision that the seminar be taught in Arabic was to encourage participants to begin creating the Arabic language of recovery. Having studied at the university in Hebrew, the practitioners did not have the opportunity to learn about recovery in their own language. It thus seemed essential to create understandable communication between service providers and the recipients especially as most of the literature in the field they are exposed to is not in Arabic. As a solution to the issue of terminology, an idea was raised by one of the students to create a collection of rehabilitation, therapy and mental health concepts in Arabic. As part of this effort, the first 10 minutes of each seminar meeting were devoted to creating a glossary of central terms in recovery. All students were expected to prepare in advance commonly used terms related to recovery and these were discussed and summarized with the goal to reach a consensus regarding the meaning of each concept. The dictionary grew in a steady, tangible manner.

It helped create a lingua franca that enhanced the confidence of students to plan and carry out their projects. Distribution of the glossary could facilitate the task of Arabic speaking service providers in their communities and ensure a respectful, top standard service to the Arab population of Israel.

Project two: Empowering wives of consumers in the village of Iksal, near Nazareth involved recruiting the village social services department to identify who might be good candidates and benefit from the project. Thirteen wives of mental health consumers began attending a weekly support group. The content was selected on the basis of personal interviews during which they shared the topics that were important to them, colored by their role as wives and mothers in the shadow of the disorder of the husband and father and its impact on themselves and their children.

Project three: Involving consumers in activities at the social-vocational club in Shefaram. Two students, jointly with the social services department and the club's social workers, identified eight families with a member

suffering from a psychiatric disorder. The project was mainly conducted through home visits during which the students got acquainted with the consumer and his family and tried to motivate him to join the club activities.

Project four: Raising awareness to mental health issues among 10th grade students in an Arab school in Haifa. Two students held eight meetings with 73 pupils, discussing stigma, mental health, treatment for mental disorders, psychological stress and how social rejection among pupils impacts their mental wellbeing. Worthy of note is that after the second meeting three pupils approached the students for help with mental distress they felt, and with their consent the students referred them for professional help. In addition, a questionnaire was passed around before and after the two meetings with questions about social stigma attached to mental health disorders and psychiatric treatment. A distinct change in the level of social stigma among the pupils on the issues at hand occurred between the first and second evaluation. The response of headmaster and teachers to the project was very positive.

DISCUSSION

In this paper we describe an innovative initiative to facilitate the process of Arabic speaking MA students developing integrated cultural competences, preparing them to become the future leaders of social change in values and attitudes towards mental health issues. The goals undertaken by the seminar, "Advancing Mental Health in the Arab Sector's Projects," consisted of a. combining the students' knowledge of the Arab culture with their growing knowledge of community mental health practice; b. developing initiatives in improving consumer accessibility to mental health services, promoting change in social attitudes toward mental illnesses and their treatment and the prevention of psychiatric disorders in populations at risk. These initiatives served as training for students in providing culturally sensitive mental health services and promoting consumers' inclusion within their communities. Using the Arabic language and familiarizing therapy and rehabilitation concepts and methods helped to achieve the goal of integrating the students' knowledge of the culture with that of the field of community mental health.

However, the community activities within the Arab population that sought to promote change in attitudes toward mental illnesses were not merely culturally sensitive systemic interventions; there is an added complexity to them. These activities were carried out in with members of a minority group that struggles to develop and maintain its identity, resilience and unique characteristics as a community (33, 34), and influencing its traditional attitudes may posit a threat to their identity and perceived strength as a group. This seems to be a complex and highly sensitive mission as members in the Arab community may regard being critical of traditional values and adopting the majority's values as representing an act of oppression (35, 36). Therefore, students in the seminar had to constantly process their feelings and attitudes during numerous discussions in order to consolidate their beliefs, feel empowered by the learning process and be able to empower the recipients of their interventions. It is reasonable to assume that had the students who participated in the seminar not believed strongly in the aforementioned cause they would not have been able to successfully carry out their mission.

The processing of the students' emotional and cognitive responses as social change agents and their empowerment took place within the framework of their studies at the university. This provided the students with a safe and nourishing learning environment in which they could optimize their development and growth as new culturally sensitive professionals in community mental health. Such an environment stimulates their intellectual and emotional abilities while providing them with academic recognition (37). The seminar as a social change project has proved that an academic environment is highly recommended for strengthening the social change agent's growth as professionals and human beings.

It appears that participating in the seminar that lasted the entire academic year has contributed to the strengthening of students' two identities: as Arabs who live within a Jewish majority and as mental health professionals. Both identities are based on a strong sense of belonging to a community and sharing with others in this community values and beliefs, and engaging in the planning and carrying out of mental health promoting projects in the Arab society serves to consolidate both identities. The seminar discussions and the students' assignments have helped to crystallize their sense of who they are as professionals and as Arabs

In face of the great difficulties in the Arab society to accept western values and attitudes towards mental health issues and the poor accessibility of consumers to services, there seems to be a great need in promoting community organizations' and social and religious leaders' willingness to use these services and act to integrate consumers in their community. This policy should be implemented by Arab mental health professionals in Arabic, acting in culturally sensitive ways and integrating both their knowledge of the

culture with that of community mental health practices. These efforts should be carried out while the professionals repeatedly work out their issues and are accompanied by experienced Arab professionals who empower them as social agents and leaders in the community.

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Does Specializing in Family Medicine Improve the Detection and Diagnosis of Mental Health Problems?

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ABSTRACT

Background: Approximately half the patients seeking mental health (MH) treatment consult primary care practitioners (PCPs). Previous research indicates that patients often do not receive correct MH diagnoses or appropriate treatment from PCPs. The present study examines whether a specialization in family medicine compared to other or no PCP residency programs enhances physicians' ability to detect, diagnose and treat MH problems.

Methods: Face-to-face interviews with 49 physicans in eight clinics in Israel. Two case vignettes and questionnaires assess MH awareness and factors influencing treatment.

Results: Significantly more family practitioners (FPs) compared to others correctly diagnosed depression and anxiety vignettes were aware of patients' MH problems and prescribed psychotropic drugs.

Limitations: Small sample size, indirect examination of PCPs' skills using vignettes and the absence of psychotherapy options.

Conclusions: FPs are more likely than other PCPs to detect, diagnose and treat MH problems. To improve MH detection among a broad range of PCPs, an expanded MH curriculum should be encouraged. Additional MH training should be available for all PCPs.

INTRODUCTION

The prevalence of mental disorders among primary care patients in Europe, the United States and Israel is 20% or more (1-4). World Health Organization (WHO) data reveal that a quarter of the visits to primary care physicians (PCPs) are for mental health (MH) problems (5), and in Israel this percentage is even higher - a third of all visits (3). Research in Israel and elsewhere indicates that many patients suffering from MH problems choose not to seek care from a MH professional (6-8), but rather from a PCP (9). In Israel, this is unlikely to be related to financial reasons as both services are free of charge. General health care is delivered through four non-profit health maintenance organizations (HMOs) according to the 1995 National Health Insurance (NHI) Law (10), while mental health services are provided by the State (9) in specialty mental health clinics. A pending reform will add MH services to the mandatory basket of services provided to all residents by the HMOs. This is expected to produce an increased demand; PCPs will presumably be involved in responding to the anticipated increases in demand.

In addition to the high prevalence of MH problems in primary care clinics, previous research reveals that these problems are under-diagnosed by PCPs in Israel (3, 11) as well as in other Western countries (2, 12). There are numerous reasons for this, some of which are related to patients' characteristics, such as age, ethnic origin and other demographic characteristics. For example, a study conducted in South-East London found that ethnicity (Black Africans compared to Black Caribbeans

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and White English) and other demographic variables such as age (young adults), gender (female patients) and employment (full-time employment) were associated with decreased detection of psychological problems by PCPs (13). Another factor that might be associated with under-diagnosis is the finding that PCPs avoid raising mental health issues in the physician-patient encounter. In a survey conducted in 2007 in Israel, it was found that in most cases (60%) when a mental issue was discussed between patient and PCP, it was raised by the patient. Only a third of the patients with MH distress reported that the doctor initiated a discussion (14). Another factor that potentially influences the detection of mental problems is the professional background of the physician. Family medicine residency programs devote significantly more time to psychosocial issues than other PCP residency programs (15, 16). A recent study revealed that Family Practitioners (FPs) in the U.S.A. were indeed more likely to diagnose a mental health problem compared to internists (17).

In the last two decades, there has been an increasing tendency in the U.S., Canada and Europe, to include the MH subjects in the curriculum of residents specializing in family medicine, with each country differing in the subjects emphasized and the quantity of time invested (15, 16, 18-20). In Israel, the curriculum of family medicine residency also includes the topic of MH which is taught through weekly didactic courses on MH during the residency, with a strong emphasis on MH issues during clinical work. Until 2011 the residency included a required rotation of three months in a MH clinic; subsequently, a reduced rotation of two months became an elective (21). These academic experiences are designed to increase the skills and detection abilities of family physicians working in primary care settings.

In Western countries including the U.S., almost all PCPs have some specialization. Data from the AMA Physician Masterfile for 2010 (22) indicate that in the U.S. about 50% of PCPs specialized in family medicine. In the European countries such as Germany and Norway, about 50% of PCPs also specialized in family medicine (23). The same percentage is found in Israel (24), but, in contrast to the U.S. and European countries, the majority of PCPs who did not specialize in family medicine do not have any other specialization. They are considered general practitioners. The primary reason for this is the massive immigration of Jews from the Former Soviet Union (FSU) during the early 1990s when over 15,000 physicians arrived in Israel. Those with a specialization in a field that was already "saturated" were offered retraining courses to enter disciplines where there was a shortage of specialists (25). Alternatively, they received only a general medical license which enabled them to enter the less prestigious field of primary care (26).

The aim of the present study was to examine whether a specialization in family medicine enhances the ability to accurately detect, diagnose and treat primary care patients suffering from MH problems. This was accomplished by comparing FPs and other PCPs (non-specialists or specialists in other medical fields) with regard to their awareness and treatment of MH problems.

METHODS

SAMPLE

The present study is part of a larger study designed to assess the relationship between the use of medical services and psychopathology in primary care (1). In the present study, we analyzed specifically the population of PCPs (family practitioners, internists, geriatricians, some other specialists and non-specialists) who, at the time of the study (2002-2003), practiced medicine in one of eight selected clinics in Israel's largest Clalit Health Services HMO during the year prior to the interview. The clinics were selected so that their catchment population represents a cross-section of the Israeli population on the basis of geographic, socioeconomic and ethnic diversity, including clinics with a high percentage of new immigrants or Israeli Arabs. The full nature of the study was explained to the 50 PCPs from the participating clinics and all but one signed informed consent forms (N=49). PCPs were interviewed face-to-face by specially trained interviewers in the clinics. The study protocol and instruments were reviewed and approved by the Institutional Review Board (IRB) of the HMO.

MEASURES

The PCPs were asked about their medical background: A) place of medical education: "Israel"; "FSU"; "Other." B) Length of time since MD graduation: 25 or more years; less than 25 years (25 years was the median as well as the mean for the interviewed PCPs). C) Medical practice specialty: FP; other PCP (internist, geriatrician or other specialist and non-specialists).

The PCPs' awareness and practices concerning MH problems were assessed using two specially designed case vignettes supplemented by a questionnaire. Specifically,

the vignettes were used to clarify the PCP's ability to accurately diagnose MH problems (depression – ICD-10, F32 – in one vignette and anxiety – ICD-10, F41 – in the second) and the factors they consider in their recommended treatment. The case vignettes were created for this study and pre-evaluated by three MH professionals and a PCP. The two vignettes were the following: 1) Mrs. A, a 36-year-old married woman with two children, visits the doctor for the second time this month with complaints about increased fatigability and loss of interest. She does not sleep well at night and has no appetite and complains about lack of energy in the last month, to the point where she has missed work because of an inability to get up in the morning. The results of her blood tests were normal. 2) Mr. B, a 26-year-old student, single, visits the doctor, complaining of heart palpitations and nausea which have affected him recently. He is so preoccupied by this that he finds it difficult to concentrate on his studies. He also reports that he is smoking a great deal and is extremely tense and nervous.

For each vignette the PCP was asked what (s)he would do. The responses were open-ended and could be grouped into one of two major categories: (a) prescribing psychotropic drugs or (b) referring to a MH specialist. If the PCPs did not spontaneously indicate either drug treatment or referral, they were specifically asked about each possibility.

The decision of the PCP to treat depression and anxiety by prescribing psychotropic drugs was defined as a three-category variable: "No": in both vignettes the PCP did not prescribe psychotropic drugs – neither spontaneously nor prompted; "Sometimes": in one vignette only the PCP prescribed psychotropic drugs – spontaneously or prompted; "Yes": in both vignettes the PCP prescribed psychotropic drugs – either spontaneously or prompted.

The decision of the PCP to refer the patients to MH specialists was defined as a three-category variable: "No," meaning that in both vignettes the PCP did not recommend referral – neither spontaneously nor prompted; "Sometimes," meaning that in one vignette only the PCP recommended referral – spontaneously or prompted; "Yes," indicating that in both vignettes the PCP recommended referral – either spontaneously or prompted.

Finally, the PCPs were asked what diagnosis they would give for each of the vignettes. The PCPs' diagnostic accuracy was defined as a three category variable: "Incorrect for both," indicating an incorrect diagnosis in both vignettes; "One correct," indicating only one correct diagnosis; "Both correct," meaning correct diagnosis for both vignettes.

The PCPs were then given a list of factors that may have an effect on treatment decisions and they were asked if they considered these factors in their recommendations in the case of each vignette. The list included: patient's age; patient's gender; patient's family/social status; patient's extent of suffering; rules of clinic or HMO; lawsuit possibility; accessibility to MH services in the region. Each one of the seven factors was defined as a three-category variable: "No" – in both vignettes the PCP did not consider the factor as affecting his decision; "Sometimes" – in one vignette only the PCP considered the factor as affecting his decision; "Yes" – in both vignettes the PCP considered the factor as affecting his decision.

The PCPs were asked to estimate the percentage of their patients suffering from depression or anxiety. Their answers were than grouped into 3 categories: "Up to 10%"; "10-20%"; "Over 20%." They were also asked for what kind of disorders they prescribe psychotropic drugs. The responses were open-ended and they led to a new dichotomic variable, "prescribing psychotropic drugs (antidepressants and/or anxiolytics) for patients suffering from depression and/or anxiety" (yes or no).

The PCPs were told that there is a claim that there are physicians who avoid giving a psychiatric diagnosis for different reasons. The PCPs were than asked if this could be due to the stigma attached to MH; to lack of knowledge about MH; and/or to lack of time, i.e., the limited duration of each visit, which precludes a comprehensive evaluation of MH problems. Each one of these three factors was defined as a dichotomic variable (yes or no).

Finally, the PCPs were asked whether they would be interested to receive continuing education about diagnosis and treatment of psychiatric disorders in the framework of their work (yes or no).

DATA ANALYSIS

All variables were assessed for their association with medical practice specialty (FP or other PCP). Data analyses were performed using SPSS/PC version 19.0 (SPSS Inc, Chicago, IL). Two-sided tests of significance were used in all analyses (p≤.05).

RESULTS

As presented in Table 1, half of the PCPs specialized in family medicine. Among the other PCPs, 21% were internists; 8% geriatricians; 8% specialists in another

Table 1. *Personal characteristics of the primary care physicians (PCPs) by medical specialty.*

		Total		FPs[1]		Other-PCPs[2]				
		N	%	N	%	N	%	χ²	df	p
Total		49	100.0	25	51.0	24	49.0			
Gender	Male	17	34.7	9	36.0	8	33.3	.04	1	NS
	Female	32	65.3	16	64.0	16	66.7			
Place of Medical Education	Israel	14	28.6	12	48.0	2	8.3	9.55	2	.008
	FSU[3]	28	57.1	10	40.0	18	75.0			
	Other	7	14.3	3	12.0	4	16.7			
Length of Time Since Graduation (years)	≥25	25	51.0	8	32.0	17	70.8	7.39	1	.007
	<25	24	49.0	17	68.0	7	29.2			

[1] Family Practitioners

[2] Internists, geriatricians or other specialists and non-specialists

[3] Former Soviet Union

area and 63% without any specialization. The percentage of female PCPs was 65%. The majority (57%) of PCPs received medical education in the FSU, while only 29% received their medical education in Israel. The percentage of PCPs specializing in family medicine was significantly higher among those educated in Israel 86% (12/14) than among those educated in the other countries 37% (13/35). The length of time in medical practice for half the PCPs was less than 25 years. Of these, 71% (17/24) specialized in family medicine, as compared to only 32% (8/25) among those whose practice lasted more than 25 years, a significant difference.

As presented in Table 2, the responses of the PCPs to the vignettes indicate that a) 43% diagnosed correctly both of the cases of anxiety and depression, another 31% diagnosed correctly only one of the cases and diagnostic accuracy had a significant positive association with specialization in family medicine (p=.046). The same trend was observed when each diagnosis was examined separately (for anxiety, the diagnostic accuracy was 72% among FPs and 37.5% among other PCPs and for depression 72% among FPs and 50% among other PCPs; b) approximately 70% of the PCPs decided to treat the patients with psychotropic drugs, with no significant differences between FPs and other PCPs, although there was a trend for more FPs to prescribe psychotropic drugs compared to other PCPs (76% vs. 62.5% respectively). The same was true for each diagnosis separately; c) approximately half of the PCPs stated in at least one case that they would refer the patient to MH specialists, again with no significant differences between FPs and other PCPs. The same was true for each diagnosis separately;

d) almost all the PCPs stated that the characteristics of the patients in the vignettes (gender, age, family status) and the extent of suffering influenced their treatment decisions, with no significant differences between FPs and other PCPs. Only 29% of the PCPs specified that the rules of the clinic or HMO influenced their treatment decisions at least in one vignette; 55% of them mentioned the influence of the accessibility to MH services, with no significant differences between FPs and other PCPs; 51% of PCPs stated that potential lawsuits influenced their treatment decisions, with no significant differences between FPs and other PCPs, although the possibility of a lawsuit was a less influential factor for FPs (36%) than other PCPs (66%). The same trend was observed when each vignette was examined separately but was significant only for depression (20% vs. 54% p=.013).

As shown in Table 3, diagnostic accuracy (73% of the PCPs diagnosed correctly at least one of the cases of anxiety or depression in the vignettes) was significantly associated with medical specialty (88% of the FPs vs. 58% of the other PCPs, p=.019). There is also a significant association between diagnostic accuracy and length of time since graduation. The diagnostic accuracy was significantly greater among the PCPs who graduated less than 25 years ago (88%) than among those who graduated 25 or more years ago (60%) (p=.029). A significant association was also found between diagnostic accuracy and place of medical education. The diagnostic accuracy was significantly greater among the PCPs who graduated in Israel (100%) than among those who graduated outside of Israel (63%) (p=.008). Overall, the highest rate of diagnostic accuracy was among PCPs who

Table 2: *Response of primary care physicians (PCPs) to vignettes and Influencing Factor by medical specialty*

		Total		FPs[1]		Other-PCPs[2]			
		N	%	N	%	N	%	$\chi^2(2)$	p
Total		49	100.0	25	51.0	24	49.0		
Responses to Vignettes									
Diagnostic Accuracy	Incorrect for both	13	26.5	3	12.0	10	41.7	6.15	.046
	One correct	15	30.6	8	32.0	7	29.2		
	Both correct	21	42.9	14	56.0	7	29.2		
Psychotropic Drug Treatment by PCPs	No	15	30.6	6	24.0	9	37.5	1.17	NS
	Sometimes	17	34.7	9	36.0	8	33.3		
	Yes	17	34.7	10	40.0	7	29.2		
Referrals to MH Specialists	No	23	46.9	13	52.0	10	41.7	0.53	NS
	Sometimes	11	22.4	5	20.0	6	25.0		
	Yes	15	30.6	7	28.0	8	33.3		
Factors Influencing Responses									
Patient's Age	No[3]	3	6.1	0	0.0	3	12.5	3.36	NS
	Sometimes[4]	4	8.2	2	8.0	2	8.3		
	Yes[5]	42	85.7	23	92.0	19	79.2		
Patient's Gender	No[3]	7	14.3	4	16.0	3	12.5	0.55	NS
	Sometimes[4]	14	28.6	8	32.0	6	25.0		
	Yes[5]	28	57.1	13	52.0	15	62.5		
Patient's Family/Social Status	No[3]	2	4.1	0	0.0	2	8.3	2.41	NS
	Sometimes[4]	10	20.4	6	24.0	4	16.7		
	Yes[5]	37	75.5	19	76.0	18	75.0		
Patient's Extent of Suffering	No[3]	1	2.0	0	0.0	1	4.2	2.34	NS
	Sometimes[4]	4	8.2	1	4.0	3	12.5		
	Yes[5]	44	89.8	24	96.0	20	83.3		
Rules of Clinic or HMO	No[3]	35	71.4	20	80.0	15	62.5	3.67	NS
	Sometimes[4]	5	10.2	3	12.0	2	8.3		
	Yes[5]	9	18.4	2	8.0	7	29.2		
Lawsuit Possibility	No[3]	24	49.0	16	64.0	8	33.3	5.01	NS
	Sometimes[4]	9	18.4	4	16.0	5	20.8		
	Yes[5]	16	32.7	5	20.0	11	45.8		
Accessibility to Services	No[3]	22	44.9	12	48.0	10	41.7	0.71	NS
	Sometimes[4]	8	16.3	3	12.0	5	20.8		
	Yes[5]	19	38.8	10	40.0	9	37.5		

[1] Family Practitioners

[2] Internists, geriatricians or other specialists and non-specialists

[3] In both vignettes the PCP did not consider the factor as affecting the decision

[4] In only one vignette the PCP considered the factor as affecting the decision

[5] In both vignettes the PCP considered the factor as affecting the decision

Table 3: *Diagnostic accuracy1 by medical specialty and length of time since graduation or place of medical education.*

		Total		FPs[2]		Other-PCPs[3]			
		N/Total[4]	%	N/Total[4]	%	N/Total[4]	%	$\chi^2(1)$	p
Total		36/49	73.5	22/25	88.0	14/24	58.3	5.53	.019
Length of Time Since Graduation (years)	<25	21/24	87.5	15/17	88.2	6/7	85.7	0.03	NS
	≥25	15/25	60.0	7/8	87.5	8/17	47.1	3.71	NS
	$\chi^2(1)$; p	4.75; .029		0.01; NS		3.05; NS			
Place of Medical Education	Israel	14/14	100.0	12/12	100.0	2/2	100.0	–	–
	Outside of Israel	22/35	62.9	10/13	76.9	12/22	54.5	1.75	NS
	$\chi^2(1)$; p	7.08; .008		3.15; NS		1.56; NS			

[1] Correct diagnosis for at least one vignette

[2] Family Practitioners

[3] Internists, geriatricians or other specialists and non-specialists

[4] The number of PCPs with correct diagnosis of at least one vignette out of the total number of PCPs in the category.

Table 4: *Mental health (MH) practices of primary care physicians (PCPs) by medical specialty.*

		Total		FPs[1]		Other-PCPs[2]				
		N	%	N	%	N	%	χ^2	df	p
Total		49	100.0	25	51.0	24	49.0			
PCPs' Evaluation of the PCPs' Clinical Practice in MH										
PCPs' Estimate of the % of their Patients with Depression or Anxiety	Up to 10	12	24.5	4	16.0	8	33.3	8.19	2	.017
	10-20	19	38.8	7	28.0	12	50.0			
	Over 20	18	36.7	14	56.0	4	16.7			
Prescription of Psychotropic Drugs	No	16	32.7	5	20.0	11	45.8	3.72	1	NS
	Yes	33	67.3	20	80.0	13	54.2			
Reason for PCPs Avoiding Psychiatric Diagnoses:										
Stigma	No	15	30.6	7	28.0	8	33.3	0.16	1	NS
	Yes	34	69.4	18	72.0	16	66.7			
Lack of Knowledge	No	20	40.8	15	60.0	5	20.8	7.78	1	.005
	Yes	29	59.2	10	40.0	19	79.2			
Lack of Time	No	12	24.5	8	32.0	4	16.7	1.56	1	ns
	Yes	37	75.5	17	68.0	20	83.3			
Interest in Continuing MH Education	No	7	14.9	4	16.0	3	13.6	0.05	1	ns
	Yes	40	85.1	21	84.0	19	86.4			

[1] Family Practitioners

[2] Internists, geriatricians or other specialists and non-specialists

studied medicine in Israel (14/14=100%) for whom the majority (80%) were FPs and graduated more recently, while the lowest rate was among other PCPs for whom time since graduation was 25 or more years and who received medical education outside of Israel (7/16=44%) ($\chi^2(1)$=11.25; p=.001) .

As presented in Table 4, two aspects of the PCPs' evaluation of their own clinical practice were found to be associated with specialization 1) significantly more FPs than other PCPs estimated that more than 20% of their patients suffered from depression or anxiety (56% vs. 17%, p=.017); 2) 80% of the FPs indicated that they prescribe psychotropic drugs compared to 54% of other PCPs (p=.054).

Overall, three quarters of the PCPs indicated that lack of time was a reason for avoiding psychiatric diagnosis,

70% indicated stigma and 60% lack of knowledge. Lack of knowledge was found to be associated with specialization: 40% of FPs compared to 80% of other PCPs indicated lack of knowledge (p=.005). The majority of the PCPs (85%) expressed interest in continuing education regarding MH in the framework of their work.

DISCUSSION

The current research reveals the importance of a specialization in family medicine, which includes teaching and training in mental health areas, in terms of diagnostic accuracy and treatment decisions. Responses to the vignettes showed the preference of FPs to prescribe psychotropic drugs while the other PCPs are more likely to refer patients to MH services. In addition, FPs compared to others reported a higher percentage of their patients with depression and/or anxiety symptoms. This difference is consistent with previous research showing that FPs are more aware of MH problems among their patients than other PCPs, and that they tend to detect MH problems more than internal medicine specialists (17). This suggests that FPs are more willing than others to take treatment responsibility for MH problems rather than referring them to MH specialists (27) which may be consistent with having more therapeutic confidence (28). Furthermore, the enhanced confidence of FPs may be related to the trend for them to be less concerned about possible malpractice lawsuits compared to other PCPs.

Additionally, a higher percentage of other PCPs indicated a lack of knowledge regarding MH issues as a reason for not making a psychiatric diagnosis. This could be related to the fact that family medicine programs devote significantly more time to psychosocial issues than other PCP residency programs (15, 16). Indeed, the majority of PCPs in this study, similar to other studies, felt that MH training is very important and expressed interest in furthering their education in these issues (19, 29).

In the present research, only 50% of PCPs were FPs, similar to other Western countries (22, 23). However, in contrast to these countries, in Israel the majority of other PCPs had no specialization recognized by the Israeli Medical Association, as described previously (24).

Two other factors related to improved diagnostic accuracy include receiving medical education in Israel and more recent graduation. Most physicians not educated in Israel came from the FSU in the early 1990s. Since there were cultural and political stigmas attached to MH problems (30), a reasonable assumption is that MH issues

received little or no attention in medical curricula. The positive effect of more recent education may reflect the emphasis on MH in curricula during the last decades.

One of the limitations of the study is the small sample size which allows only bivariate analyses. Another limitation is that PCPs' actual skills in diagnosis and treatment, were not examined directly but indirectly through questionnaires and vignettes. An additional limitation is that PCPs were asked only about two options, prescribing psychotropic drugs or referring to a MH specialist. The option of CBT or any other psychological intervention was not offered. Despite these limiations, the results are important since the effect of specialization in family medicine on the ability to detect, diagnose and treat MH problems is seldom addressed.

CONCLUSION

The results of the present study confirm that FPs compared to other PCPs are more likely to detect, diagnose and treat MH problems. This is consistent with the curricula for family medicine specialization giving significantly more attention to MH than curricula for other specializations (15, 16). Accordingly, specialization in family medicine should be encouraged. Moreover, additional MH training should be available for all PCPs.

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Psychiatric Consultation in Community Clinics: A Decade of Experience in the Community Clinics in Jerusalem

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ABSTRACT

Introduction: A consultation model between primary care physicians and psychiatrists that has been in operation for 12 years in the Jerusalem district of the Clalit Health Services in Israel is evaluated. In this model psychiatrists provide consultations twice a month at the primary care clinic. All patients are referred by their family physicians. Communication between the psychiatric consultant and the referring physician is carried out by telephone, correspondence and staff meetings.

Objective: Evaluation of the psychiatric care consultation model in which a psychiatrist consults at the primary care clinic.

Method: A questionnaire-based survey distributed to 17 primary care physicians in primary care clinics in Jerusalem in which a psychiatric consultant is present.

Results: Almost all of the doctors (93%) responded that the consultation model was superior to the existing model of referral to a secondary psychiatric clinic alone and reduced the workload in caring for the referred patients. The quality of psychiatric care was correlated with the depression prevalence among patients referred for consultation at their clinic (r=0.530, p=0.035). In addition, correlation was demonstrated between primary care physicians impression of alleviation of care of patients and their impression of extent of the patients' cooperation with the consulting psychiatrist (r=0.679, p = 0.015)

Conclusions: Very limited conclusions may be drawn from this questionnaire distributed to primary care physicians who were asked to assess psychiatric consultation in their clinic. Our conclusion could be influenced by the design and the actual distribution of the questionnaires by the consulting psychiatrist.

Nevertheless answers to the questionnaire might imply that the consultation model of care between a psychiatric consultant and the primary care physician, where the patient's primary care physician takes a leading role in his psychiatric care, is perceived by family physicians as a good alternative to referral to a psychiatric clinic, especially when treating patients suffering from depression.

INTRODUCTION

Family physicians have a central role in the preliminary diagnosis and treatment of psychiatric illness. Most of the patients suffering from mental illness are seen and diagnosed for the first time by their family physician and about half of them do not come for psychiatric consultation (1). At the lower socio-economic levels, the percentage of patients being treated by a psychiatrist is even lower, and the role of the family physician as the main provider of care for psychiatric illness is even greater (2). In Israel accessibility and use of primary care services have been shown to be high relative to U.S.A. and Europe. Prevalence of mental disorders among patients seeking medical care in primary care in Israel was 42%: one out of five visits for depressive episodes and one out of six visits for anxiety disorder (3).

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Various models of cooperation between a psychiatric consultant and the primary care physician in the community have been examined. These models demonstrated an increase in the rate of diagnosis and treatment of mental illness among populations of low socio-economic standing (4, 5), and depressed patients made fewer visits to health care providers when a psychiatrist was involved in their care (6). The comparison of the treatment in the models of cooperation and the accepted model of psychiatric treatment with no involvement of the primary care physician demonstrated identical rates of success in anxiety disorders and depression in particular (7, 8) and in psychiatric disorders in general (9), but the model was not proven to be better in terms of economic cost-benefit (7, 8). A number of studies demonstrated that treating family physicians prefer the model of structured institutional cooperation with a psychiatrist over the accepted method of referring for psychiatric consultation (10-12). Cooperation will improve when the consulting psychiatrist is familiar with the needs of the community with which the family physician works, and is aware of the level of knowledge and skills of the primary care physician to whom he provides consultation services (13).

The advantages of psychiatric consultation from the perspective of the family physician are: accessibility to the psychiatric consultant in the primary care clinic without stigma for patients, accessibility of psychiatric consultation for the treating physician (14, 15) and the acquisition of better knowledge in psychiatry (16, 17). The consulting psychiatrists acquire a more holistic perspective of their patients and learn to appreciate the importance of treatment of psychiatric issues by the family physician (18).

For the past decade, in ten primary care clinics of the Clalit Health Services in Jerusalem, a psychiatric consultant visits every other week for five hours of consultation, in order to evaluate and treat patients referred by family physicians. Almost all of the patients are referred by their family physician, who is not present at the meeting with the psychiatrist. Decisions regarding further treatment and evaluation are made by the psychiatrist in coordination with the referring physician. Communication between the primary physician and the psychiatrist is through written correspondence, telephone conversation and staff meetings where clinical cases are discussed. No follow-up service was developed since it was intended that patients be referred back to the primary care physician. It was the consulting psychiatrist's decision whether to refer patients to the municipal psychiatric clinic if needed. The service has no social worker and nurses do not take an active role in this initiative. Social work help is provided by the municipality services.

OBJECTIVE OF THE QUESTIONNAIRE

The objective of the questionnaire was to examine the advantages and disadvantages of psychiatric consultation in the community from the perspective of the family physician.

STUDY METHODOLOGY

Questionnaires were given to 17 family physicians in the community clinics in which psychiatric consultations are provided. The questionnaires included demographic and professional questions, and attitudes toward psychiatry, evaluation of the quality of care in terms of the availability of the psychiatric consultant and patient compliance, the extent to which the family physician enhanced his knowledge of psychiatry and if the use of the new model had any effect on the workload of caring for these patients. The attitude questions were measured on a scale of 1 to 5, the higher the score the more positive the attitudes.

In addition, the distribution of the psychiatric diagnoses of the patients seen by the psychiatric consultant was compared to the distribution of psychiatric diagnoses in the entire Jerusalem district who had a psychiatric diagnosis in their file. The databases of both the intervention clinics and the entire Jerusalem district were the patients' computerized medical files in their primary care clinics (psychiatric diagnoses for patients seen by psychiatrists in this consultation model were retrieved from both manual and psychiatric computerized files).

Data analysis was conducted using the SPSS program, version 19. The distribution of the findings was described by percentages and measures of central tendency and measures of dispersion. The Mann Whitney test was conducted for independent samples to examine the differences in the preference for the model between variables of two categories. The correlation between continuous variables was examined using the Spearman's coefficient. A P-value of less than 0.05 in either direction was considered statistically significant.

RESULTS

Seventeen primary care physicians participated in the consultation model, consisting of 13 experts in family

medicine, three general primary care physicians and one geriatrician, mean age 51.1 years (sd 11).

ANALYSIS OF THE QUESTIONNAIRES GIVEN TO PRIMARY CARE PHYSICIANS (BOTH SPECIALISTS IN FAMILY MEDICINE AND GENERAL PRACTITIONERS) (N=17)

Interest in treating patients according to the model relative to the default method increased as the psychiatric depression case load increased (r=0.530, p=0.035). Additionally, a positive correlation was found between the receipt of feedback from the consulting psychiatrist in the clinic and the evaluation of the quality of psychiatric treatment provided in the model, in comparison to the existing referral of patients to a secondary psychiatric clinic (r=0.508, p=0.053).

ANALYSIS OF THE QUESTIONNAIRES AMONG ONLY EXPERTS IN FAMILY MEDICINE (N=13) AND GERIATRIC MEDICINE ONLY (N=1): (EXCLUDING THREE GENERAL PRIMARY CARE PHYSICIANS)

A positive correlation was found between the degree to which the family physician appreciated the model of consultation in the community clinic and his impression of their patients' compliance (r=0.630, p=0.028) and receiving feedback from the consulting psychiatrist in the clinic (r=0.829, p=0.002). A positive correlation was found between receiving feedback from the consulting psychiatrist and the extent of the primary care physician's interest in psychiatry (r=0.730, p=0.007) and the contribution of the psychiatric consultation to the primary care physician's medical knowledge in the field of psychiatry (r=0.757, p=0.003). In addition a positive correlation was found between receiving feedback from the consulting psychiatrist and the primary care physician's impression that psychiatric consultation in the community clinic lessens the workload of treating patients referred for consultation (r=0.679, p=0.015).

A significant statistical difference was observed between the rates of mental illness in the Jerusalem district in general and patients in community clinics where psychiatric consultation was provided (Table 2).

DISCUSSION

A positive correlation was found between the primary care physician's estimated rate of depression in the patient population and his evaluation of the psychiatric advice that he received in the community clinic family physicians. These data are consistent with other studies that

Table 1. *Physician's attitude regarding the psychiatric consultation model in primary care clinics (n=17)*

	N	%
Interest in psychiatric consultation in the community		
Great extent	10	59%
Moderate extent	7	41%
Low extent	0	0
Consultation model perceived to be better than the model of referring patients to a secondary psychiatric clinic		
Yes	16	94%
No	1	6%
Patient's compliance perceived as superior in this psychiatric consultation model		
Great extent	5	29%
Moderate extent	12	71%
Low extent	0	0
Psychiatric consultation contribution to primary care physician's knowledge of psychiatry		
Great extent	8	47%
Moderate extent	9	53%
Low extent		
Primary care physicians evaluation of feedback from the psychiatric consultant in the clinic as being satisfactory to a great extent		
Yes	11	65%
No	6	35%
Impression that psychiatric consultation model lessened primary care physician's workload		
Great extent	7	41%
Moderate extent	9	53%
Low extent	1	6%

examined the role of the family physician in treating depression disorders. It is possible that this consultation model strengthens the family physician's ability to treat patients suffering from a depression syndrome (6).

In general it was found that receiving feedback from the treating psychiatrist, the extent of the primary physician's interest in psychiatry and the contribution to the primary physician's knowledge of psychiatry had a central role in the success of the treatment model only where the primary physician was a specialist in family medicine. This may suggest that the model is successful mainly where the primary care physician is a specialist in family medicine. These findings are consistent with

Table 2. *Distribution of psychiatric diagnoses of patients referred for psychiatric consultation in the primary care clinic compared to psychiatric diagnoses in primary care files in the Jerusalem district*

Diagnosis groups	Jerusalem district N=71418		Study N=406		χ^2 ,p-value
	N	%	N	%	
Schizophrenia	3,356	4.7%	26	6.4%	χ^2=2.61, P=0.105
Personality disorder	429	0.6%	39	9.6%	χ^2=505.7, P<.001
Anxiety disorder	1,459	2.0%	37	9.1%	χ^2=98.95, P<.001
Bipolar affective disorder	716	1.0%	15	3.7%	χ^2=29.04, P<.001
Depression	33,125	46.4%	191	47.0%	χ^2=5.82, P=0.01
Adjustment disorder	3,151	4.4%	60	14.8%	χ^2=101.5, P<.001
Dementia	4,226	5.9%	4	0.9%	χ^2=17.7, P<0.01
Other*	24,956	34.9%	34	8.4%	χ^2=37.2, P<.001

*Includes: eating disorder, gender identity disorder and attention deficit disorder

another study that demonstrated that specialists in family medicine in Israel are more interested in psychiatric care of patients and are more sensitive to psycho-social issues as compared to physicians with other specialties (19).

Another interesting finding is that specialists in family medicine estimated that the cooperation with the psychiatrist decreased their workload in treating these patients and that the psychiatric treatment administered by the family physician may be the reason for this.

The consult recommendations were not reviewed. Modalities of treatment were drug treatment and referral to psychotherapy as available in the Jerusalem district which were not provided in the primary care clinics. As a large percentage of patients referred for consultation suffered from depression it can be argued that their management might have been compromised since psychotherapeutic intervention such as CBT were not provided on site, and psychiatrists may tend to offer medication despite guidelines such as NICE (20). These services were provided by a mental health clinics where patients were referred if appropriate.

Table 2 demonstrates differences of the distribution of psychiatric disorder between the consultation sample and the whole district of Jerusalem. Higher prevalence of depression, adjustment disorder personality disorder and anxiety disorder were observed in the consultation sample. These differences can be explained by a possible difference in the socio-demographic characteristics of the interventional clinics in comparison to the entire Jerusalem district, and that data of psychiatric illness in the whole of Jerusalem district were retrieved from primary care physicians' medical files, in distinction to diagnoses made by psychiatrists. Consequently, underreporting of psychiatric disorder could bias the general community findings. However, it is possible that psychiatric consultation in the primary care clinic constitutes a unique address that enables patients who would otherwise not go for consultation in a secondary care center. Hence it might be argued that this model enables the diagnosis and treatment of more patients suffering from psychiatric illnesses who are otherwise not diagnosed. It is noteworthy that patients suffering from somatization disorder were not referred to psychiatric consultation. It is our assumption that these patients were diagnosed and managed by their family physicians who share the general belief that their treatment could not be enhanced by psychiatrists.

LIMITATIONS

Very limited conclusions could be drawn from this modest enterprise of assessing this psychiatric consulting model. An additional psychiatric service was being added so that it was unlikely that any finding would be other than positive.

Furthermore, the sample of 17 respondents is small,

and the questionnaire was given out by the psychiatrists. The study subjects were aware who would read their answers.

CONCLUSION

Very limited conclusions can be made from this questionnaire distributed to primary care physicians who were asked to assess psychiatric consultation in their clinic. Our conclusion could be influenced by the design and the distribution of the questionnaire by the consulting psychiatrists.

Nevertheless, this questionnaire may demonstrate the advantages of psychiatric consultation for patients in the community clinics where there is cooperation between the consulting psychiatrist and the primary physician, from the vantage point of the family physicians. The family physicians found the model to be particularly effective for the treatment of patients suffering from depression and their impression was that it reduces their workload in treating these patients. The percentage of patients suffering from depressive disorder, anxiety disorders and personality disorders who were seen in the primary care clinics by the consulting psychiatrist was higher than its incidence in the general population.

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על העומס הטיפולי בחולים אלה. נמצא מתאם בין התרשמות הרופא הראשוני מאיכות הטיפול הפסיכיאטרי שניתן במודל זה לבין שכיחות דיכאון בקרב החולים שהופנו לייעוץ פסיכיאטרי ע"י הרופא הראשוני (r=.530 p=.035). בנוסף נצפה מתאם בין התרשמות הרופא הראשוני ביחס להקלת העומס במרפאה בטיפול בחולים אלה ובין מידת שיתוף הפעולה עם הפסיכיאטר היועץ (r=.679 p=.015).

מסקנות: נתן להגיע למסקנות מוגבלות מאוד מהשאלונים שמולאו על ידי רופאים ראשוניים שנתבקשו להעריך את הייעוץ הפסיכיאטרי במרפאתם. יתכן שמסקנותינו מושפעות ממבנה השאלונים ומהעובדה כי השאלונים חולקו לרופאים הראשוניים ע"י הפסיכיאטר היועץ במרפאה.

למרות זאת, יתכן והתשובות לשאלונים מרמזות שמודל טיפולי שבו הרופא הראשוני לוקח חלק מרכזי בטיפול בתחלואה פסיכיאטרית, תוך שיתוף פעולה עם פסיכיאטר יועץ במרפאתו של הרופא הראשוני, נתפס על ידי רופאי משפחה כמודל חלופי טוב לטיפול המקובל של הפניה למרפאה פסיכיאטרית, כאשר המדובר בדיכאון.

ייעוץ פסיכיאטרי במרפאות הקהילה – ניסיון של עשור במרפאות הקהילה בירושלים

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הקדמה: בעבודה זו אנו בוחנים מודל טיפולי, של שתוף פעולה בין יועצים פסיכיאטריים ורופאים ראשוניים המתקיים מזה שתים עשרה שנים בשירותי בריאות כללית במחוז ירושלים. במיזם זה מגיע יועץ פסיכיאטרי למרפאות הקהילה אחת לשבועיים, לצורך הערכה וטיפול בחולים המופנים על ידי רופאי המשפחה. התקשורת בין היועץ הפסיכיאטרי ורופא המשפחה מתבצעת בטלפון, בתכתובת ובישיבות צוות.

מטרות: הערכת הטיפול בתחלואה פסיכיאטרית במסגרת מרפאות ראשוניות ברפואת המשפחה, במודל טיפולי שבו היועץ הפסיכיאטרי מגיע לייעוץ במרפאות הקהילה.

שיטות מחקר: סקר מבוסס שאלונים שניתנו ל 17 רופאים ראשוניים במרפאות הקהילה בהם מגיע הפסיכיאטר לייעוץ.

תוצאות: כמעט כל הרופאים במחקר (93%) העריכו כי המודל הנוכחי טוב יותר בהשוואה למודל הקיים של הפניית חולה למרפאה פסיכיאטרית. כל הרופאים סברו כי מודל זה הקל

שטיפולים קהילתיים טובים יותר מהתערבויות מרפאתיות.

מסקנות: יש עדות לכך שניתן ליישם תוכנית בריאות נפש המבוססת בקהילה עם בתי הספר באמצעות גישה מולטי–סקטוריאלית עם תוצאות טובות, שהיא אפקטיבית מבחינת עלות.

המעבר מאשפוז פסיכיאטרי לחיים בקהילה: אתגרים מקומיים ועכשוויים

א. חסון-אוחיון | רמת גן

בעוד שבישראל ובעולם נעשו בעשורים האחרונים מאמצים נרחבים לקידום שירותי בריאות הנפש בקהילה, דגש מועט יותר הושם על המעבר המאתגר מאשפוז פסיכיאטרי לחיים בקהילה. המאמר הנוכחי סוקר את הספרות על תוכניות והתערבויות של שחרור מאשפוז פסיכיאטרי ומעבר לקהילה שמראה כי עבודה של צוות אינטרדיסציפלינרי והתאמה של מודל ניהול מקרה כך שיכולול חפיפה בקשרים בתהליך של שינוי הסטינג הטיפולי יכולות להוביל לתוצאות שהן כדאיות כלכלית. הרפורמה העכשווית בבריאות הנפש בישראל מהווה הזדמנות לחשיבה מחדש על הצרכים של אנשים המתמודדים עם מחלות נפש קשות ועל סדרי עדיפויות תקציביות. חשיבה שכזו יכולה להוביל לפיתוח ויישום של תוכניות שחרור ולמעבר מוצלח מאשפוז פסיכיאטרי לחיים בקהילה.

מחקר אמפירי על הקשר בין שילוב בקהילה, החלמה ואיכות חיים בקרב אנשים אם מחלות נפש קשים

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רקע: החלמה ואיכות חיים הם תוצאות מפתח עליהם שמים דגש במערכות בריאות הנפש בכל העולם. מחקר זה בוחן את המידה שבה המאמצים לקדם שילוב בקהילה עשויה לשפר את התוצאות הללו.

שיטות: 606 אנשים עם מחלות נפש קשים מלאו מדדי שילוב, החלמה ואיכות חיים.

תוצאות: נמצאו קורלציות קטנות אך משמעותיות סטטיסטית בין שילוב בקהילה, החלמה ואיכות חיים. ניתוחים נוספים זיהו תחומי שילוב מסוימים אשר תרמו לרמות גבוהות יותר של החלמה ואיכות חיים כאשר המחלימים ראו בהם חשיבות והשקיעו בהם במידה מספקת.

מגבלות: ניתוחי מיתאם לא מאפשרים הסברים סיבתיים.

מסקנות: התוצאות מראים שדגש חזק יותר על שילוב בקהילה, במיוחד בתחומים שחשובים לאדם ושמבוצעים בצורה מספקת יכולים לקדם החלמה ואיכות חיים במערכות בריאות נפש קהילתיים. השלכות וכיוונים אפשריים למדיניות ונהלים, במיוחד בהקשר של השירותים בסל השיקום הפסיכיאטרי בישראל, מוצעות.

הכשרת אנשי מקצוע מהמגזר הערבי להתערבויות קהילתיות רגישות תרבות בבריאות הנפש

א. ח׳טיב, ד. רועה, ח. ירושלמי | חיפה

המאמר הנוכחי מתאר יוזמה חדשנית שנועדה לסייע בהכשרתם של סטודנטים להתערבויות רגישות תרבות במטרה לקדם את נושא בריאות הנפש בחברה הערבית בישראל. השגת מטרה זו נעשתה באמצעות בנייתו ויישומו של סמינר שנתי עבור סטודנטים ערבים, המנוהל בשפה הערבית ומבוסס על שימוש במקורות קריאה וספרות מחקרית מהעולם הערבי. המאמר מתאר את הצורך, פתוח ובניית הסמינר, תהליך הלמידה והתוצאות של המיזמים הקהילתיים כפי שתוכננו ויושמו על ידי הסטודנטים בסמינר. המסגרת האקדמית המתוארת מזינה התגלתה כסביבה המסייעת בתהליך הכשרתם וצמיחתם של מנהיגים חברתיים עתידיים שביכולתם לחולל שינוי חברתי בנושאי בריאות הנפש.

מלות מפתח: כשירות תרבותית, הכשרה בבריאות נפש, חנוך.

האם התמחות ברפואת המשפחה משפרת את האיתור והאבחון של בעיות נפשיות?

צ. הורוניץ-לוריא, ג׳. צווייקל, נ. זילבר, מ. פיינסון, א. בידרמן, י. לרנר | ירושלים ובאר שבע

רקע: כמחצית מהמטופלים מעדיפים לפנות לרופא ראשוני (רופא משפחה) לעזרה נפשית. מחקרים קודמים מצביעים על כך שלא תמיד המטופלים מקבלים אבחנה נפשית נכונה ו/או טיפול מתאים מהרופא הראשוני. המחקר הנוכחי בוחן האם התמחות ברפואת המשפחה לעומת התמחויות אחרות או העדר התמחות, תורם ליכולת של הרופא הראשוני לאתר, לאבחן ולטפל בבעיות נפשיות.

שיטה: נערכו ראיונות פנים אל פנים עם 49 רופאים בשמונה מרפאות ראשוניות בישראל. כלי המחקר כללו שני סיפורי מקרה ושאלונים להערכת המודעות לבעיות נפשיות וגורמים המשפיעים על הטיפול בהן.

תוצאות: רופאים שעברו התמחות ברפואת המשפחה, אבחנו נכון יותר את סיפורי המקרה של דיכאון וחרדה, היו מודעים יותר להימצאות בעיות נפשיות בקרב מטופליהם וכן נטו לרשום יותר תרופות פסיכותרפיות בהשוואה לשאר הרופאים הראשוניים.

מגבלות: מדגם מצומצם, הערכה עקיפה של כישורי הרופאים הראשוניים על ידי שימוש בסיפורי מקרה והעדר התייחסות לאפשרויות טיפול מסוג פסיכותרפיה.

מסקנות: רופאים שעברו התמחות ברפואת המשפחה נוטים יותר לאתר, לאבחן ולטפל בבעיות נפשיות, יחסית לרופאים ראשוניים אחרים. כדי לשפר את יכולתם של כלל הרופאים הראשוניים לאתר בעיות נפשיות, יש לעודד הרחבת תוכנית הלימודים בנושא בריאות הנפש. הכשרה נוספת בתחום בריאות הנפש צריכה להיות זמינה לכל הרופאים הראשוניים.

כתב עת ישראלי לפסיכיאטריה

תקצירים

מדיניות בריאות הנפש הקהילתית בארצות הברית: לקחים

ג'. גרוב | ארה"ב

אחרי 1945, הקונגנזוס הרווח שצריך לטפל באנשים עם הפרעות נפשיות חמורות בבתי חולים ציבוריים החל להתמוסס. הוא הוחלף באמונה ביעילות הטיפול בקהילה. עם זאת, עבור מגוון סיבות, מערכת הטיפול בקהילה לא עמדה בציפיות. התומכים ברעיון לא הצליחו להבין שהבעיות של אנשים עם מגבלות חמורות ומתמשכות היו שונות מאלה עם הפרעות קלות ובינוניות. האמונה שמגורים בקהילה יקדמו הסתגלות ושילוב היתה סוג של אשליה אשר לא לקחה בחשבון את ההיקף של בידוד חברתי, חשיפה לקורבנות, נטיה לשימוש בסמים, מחוסרי בית, והתייחסות לבעלי הפרעות נפש כעבריינים. טיפול יעיל בקהילה עבור אנשים ששהו בעבר בבתי חולים חייב על טווח רחב של פונקציות שהאשפוז נועד לספק, מדיור ופיקוח ועד לטיפול ושיקום.

שחזור אזרחות / לקבל אזרחות חזרה

מ. רואו, ל. דוידסון | ניו הייבן, ארה"ב

ההחלמה כתהליך שבאמצעותו אנשים תובעים בחזרה את חייהם אפילו כאשר הם ממשיכים לחוות סימני מחלות נפש, לעתים לא הובנה או לא פורשה כהלכה, לרבות היותו משמש כתירוץ לבטל שירותים ותמיכה נחוצים במסווה של מתן אפשרות לאנשים להמשיך ב"מסעות החלמה אישיות". בהעברת מסר של תקווה לאנשים וטיפוח יוזמות נגד ההשפעה המשתקת של פסימיות קלינית, ספרות ההחלמה לעיתים הקדישה פחות תשומת לב להקשרים חומריים, חברתיים, תרבותיים, פוליטיים וכלכליים, אשר דרכם אנשים שואפים להחלמה. רמזים לחשיבות ההקשרים הללו הופיעו בדו"ח אמריקאי על מחלות נפש ובריאות משנת 1961, אשר טען שאנשים עם מחלות נפש זכאים לחיות את חייהם "באופן נורמלי" בקהילה. אנו טוענים למודל נכות שמספק לאנשים את התמיכה והשירותים הנחוצים כדי לאפשר החלמה אינדיבידואלי עבור אנשים עם מחלות נפש ארוכי טווח. מודל נוסף שהתפתח בעשור האחרון כדי לאזן את הדגש היומרני על היחיד במסעו להחלמה הוא אזרחות. אנו דנים במושג זה ובמחקר שלנו בתחום מאז שנות ה90 המאוחרות. אנו טוענים ל"תביעת אזרחות" כמושג וכמטאפורה כדי לכבוש את תהליך ההחלמה האינדיבידואלי, במסגרת הקשר והמטרה של חיי קהילה, שמסגרת האזרחות תומכת בו.

שיפור שירותים קהילתיים לבריאות נפש: הצורך בשינוי פרדיגמה

א. לונגדן, ג'. ריד, ז'. דילון | ליברפול

רקע: עבר יותר מחצי מאה מאז החל טיפול בקהילה בעקבות סגירת מערכת בתי החולים הפסיכיאטרים הישנה. מאמר זה שוקל האם שירותי בריאות נפש, ללא קשר למיקום, אכן יכולים להיות יעילים ואנושיים ללא שינוי פרדיגמה בסיסי.
נתונים: סיכום מחקרים על התקפות והיעילות של גישות טיפול בתחום בריאות הנפש הנוכחיות מוצג.
מגבלות: היקף הנושא היה רחב מדי כדי לתמוך בסקירה שיטתית או מטה-אנליזה, אך סקירות ממוקדות יותר מצוטטות.
מסקנות: המעבר לטיפול בקהילה לא הצליח לקדם גישה יותר פסיכוסוציאלת וממוקד החלמה. במקום זה הוצא המודל הרפואי עם הטכנולוגיות שלה, לעתים קרובות מלווה בכפייה, לתחום רחב בהרבה מבית החולים. עם זאת, יש כמה סימנים מעודדים ששינוי פרדיגמה שאיחר לבוא אכן מתקרב.

בריאות נפש קהילתית כגישת בריאות הנפש מבוססת אוכלוסייה

ס. ו. קאי, ד.ש.ש.פונג, | סינגפור

רקע: שירותי בריאות הנפש לבני נוער בסינגפור אותגרו על ידי אילוצי נגישות ומשאבים. תכנית לבריאות נפש קהילתית בשיתוף עם בתי ספר ושותפים אחרים פותחה כדי לענות לצורכי האוכלוסייה.
מטרה: לתאר הקמת תוכנית בריאות נפש קהילתית ולבחון את התוכנית על פי תוצאותיה ושביעות הרצון של המשתתפים בה.
שיטות: בהתבסס על ניתוחי הצרכים, צוותים קהילתיים רב תחומיים הוקמו ב-15 בתי ספר כדי לנווט מודל טיפול חדש עבור בני נוער. לאחר מכן התוכנית הושמה באופן הדרגתי במשך חמש שנים, רשתות של צוותים חולקו לארבעה מחוזים גיאוגרפיים. בכל מחוז היו אשכולות של 10–15 בתי ספר. הצוותים עבדו עם היועצים של בתי הספר. הצוותים נתמכו ע"י פסיכיאטר ורופא מתמחה. התערבויות התמקדו בהעצמת צוותי בתי הספר כדי שיעבדו עם התלמידים ועם המשפחות בעזרת תמיכה מהצוותים.
תוצאות: 4184 תלמידים קבלו שירות, מתוכם 10% נעזרו ע"י יועצי בית הספר ונתמכו ע"י הצוותים בקהילה. רק 0.15% נזקקו להפניה לשירותים שלישוניים. מדידת התוצאות ע"י היוצעים והמורים גילו שיפור ב-CGI, ושאלון נקודות החוזקה והקשיים. הם כללו הפחתה בבעיות רגשיות, בעיות רגשיות והתנהגויות היפראקטיביות ובעיות עם עמיתים. מעבר לכך, התנהגות חברתית השתפרה באופן משמעותי. ניתוח עלות יעילות הראה