Mental Health Centre - The operating principles and its role in the prevention of psychiatric disorders and the promotion of mental health

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Summary

The Mental Health Centre is the main provider of psychiatric services in the community, serving the objective of Community Psychiatry at ensuring the psychiatric care organisation. Following the basic principles of sectorisation, therapeutic continuous, integrated services and in cooperation with other structures meets the needs of the community. Each Mental Health Centre can operate at all three levels of prevention; primary, secondary and tertiary. The detection of risk factors, the provision of quality mental health services, the early detection and management of mental disorders and the rehabilitation and social integration of patients are the main preventive measures. It should develop mental health promotion programmes aimed not only to combat risk factors but primarily to enhance the mental health both individual and public. With the increase of positive mental health, reduction of inequalities and building of social capital, the promotion of mental health aims to reduce the mental health gap between social groups and countries.

Keywords: mental health centre, community, prevention, promotion of mental health

Introduction

Community Psychiatry develops and investigates all forms exercised by psychiatry in the community. Its aim is to secure the organisation of psychiatric care based on good operation principles of a Community service and interconnection with the hospitalisation units and specialised psychiatric services (Papadimitriou et al. 2013). The mental health centre (MHC) is the basic unit of outpatient psychiatry providing psychiatric services, much broader than the usual outpatient clinics which

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were historically the first form of outpatient care (Kontaxakis et al. 2010).

Operating Principles of a Mental Health Centre

One of the basic principles of the Mental Health Centre is the establishment of an area of responsibility (catchmentation - sectorisation), 70.000 - 150.000 inhabitants, in order to serve effectively as otherwise it floods with requests which cannot be satisfied in their entirety. In Europe the institution of sectors was greatly developed, but the sizes varied between countries. Germany has sectors of around 250.000 inhabitants and the Netherlands of 300.000 while the Scandinavian countries have clearly smaller areas ranging from 25.000 to 120.000. Italy has better adapted the meaning of a sector with the Law 180 of 1978 and created sectors of 50.000 to 200.000 (Gelder et al., 2007). In Greece the law 2716/1999 provides that each prefecture corresponds to a sector, although for the region of Thessaloniki correspond three sectors and for Athens eleven.

The main advantages of sectorisation are the following:

o Defined responsibility for each person who seeks help
o Network of local connections between the institutions of the sector and development of connections between institutions of primary health care
o Comparability of the services in different sectors
o Strengthening of cooperation of the treating team members with the community
o Better transparency in the budget
o Enhancement of treatment at home or day care provider
o Possibility to be treated and cared for by different carriers in the same sector
o Ability to integrate healthcare, social and voluntary services

It is obvious that all the mental health services are provided to the community. The community oriented services emphasise the daily care so that the mentally

ill patients can continue living integrated in society (Ministry of Health, 2006). An issue to be resolved regarding the sectored services is that they offer less potential options of therapists to patients. However, a well organised local service can in most cases respect the wish of a patient to change clinician, transferring the case to another team member or in some cases to a scientific group of a neighbouring sector. The boundaries of the areas of responsibilities should be considered flexible rather than rigid and insurmountable (Gelder et al. 2007). Acceptance of an area of responsibility means also that traditional medical perception of the ill expands and extends to an entire population making more actions necessary the main being prevention (Sakellaropoulos 2010).

Another basic principle is that when psychiatry is practised in the society and not in a psychiatric hospital, the ability of the mental health professionals to determine their working conditions is reduced. Patients and their families have more scope to act in the process of meeting the personnel of the unit and the development of the therapeutic procedure. This obliges them to find appropriate ways to approach and seek allies and collaborators in the environment of the patient to implement the most appropriate therapeutic means. When the MHC gains "good reputation" in the population (e.g. with lectures, preventive interventions in the community and particularly with the seriousness and effectiveness of its function), then the approach of patients who avoid to resort to mental health services will be achieved as well as the change of the consolidated negative perception a big part of the population has for mental illness (Kontaxakis et al. 2010).

Of central importance is the easy access of the MHC, both geographically (e.g. easy service by the means of transport), and in terms of operating hours (e.g. working in the afternoon in order to be accessible to working patients) and the possibility of rapid assessment and handling incoming requests (e.g. direct service of emergency cases). The distance of a resident of the community from the MHC must be between 1 to 15 minutes. In sparsely populated areas the mobile units are very useful, as they provide psychiatric care of small towns and villages. The MHC is also required to accept all categories of patients with the exception perhaps of drug users, who usually are referred to specialised services. Must provide all the services that modern psychiatry provides (clinical monitoring, drug therapy, psychotherapy, counselling, family interventions, psychological support, brief psychiatric hospitalisation, hospital or day centre etc.) through the appropriate medical staff, psychologists, nurses, social workers and occupational therapists (Kontaxakis et al. 2010). In case the hospitalisation is necessary, it must be done if possible in a brief hospitalization unit of the Mental Health Centre

or in small interconnecting hospital units (e.g. the CMHC of Vironas-Kaisariani with Eginition hospital) (Madianos 2000) and the residence time to be reduced to the least possible. The specialised clinics (e.g. psycho-geriatric, specific psychotherapies etc.) can be organised with the cooperation of more community psychiatric units (Papadimitriou et al. 2013).

Moreover, it has been shown that the lack of continuity in the treatment and in the services provided from units, which do not cooperate with each other, is a negative factor especially noticeable in the care of severe mental conditions (e.g. schizophrenia and affective psychoses). The accumulation of unrelated provided services is a burden also to the cost of the psychiatric service. The MHC having the responsibility for the population, must ensure the continuity and coordination of these services and actions. Where reference is made to other services, the MHC maintains the moral responsibility of the continuity (continuity of care) and its coordinating role (Ministry of Health 2006). Furthermore, in order to operate effectively, the MHC cooperation with other hospitals on issues related to hospitalisation and specific forms of patient care is fundamental.

An important issue, which must be explored, is the effective cooperation with of primary health care providers (general practitioners, multipurpose health centres, etc.), as physicians of other specialties monitor a large number of patients (comprehensiveness), who present mainly anxiety and depression symptoms (Ministry of Health, 2006). This collaboration is particularly important in the care of psycho-geriatric cases, due to the coexistence of multiple health problems.

Another principle is the establishment of mental health professionals into a team (mental health group – therapeutic team). In a MHC are employed people who belong to several professional groups with different initial education and roles. In the traditional asylum the authority of a psychiatrist was unquestioned and was limited only by the legal provisions concerning the inclusion process. The nursing staff and later on the clinical psychologists, the social workers and occupational therapists, constituted the "paramedical support staff" in a subordinate position. The creation of multi-purpose teams working in various combinations gave to the psychiatrist a coordinating role, which became more and more complicated due to the demands of professional autonomy by the, until now, "paramedical professions". In certain cases, mostly in MHCs in USA, the psychiatrists who were a small minority in the group and had an increasingly less control over its operation, resented what they considered to be loss of their medical status (Gelder et al. 2007). However, working in an open social environment constantly generates new organic and functional needs and thus requiring ongoing education

and overcoming the old roles. Through continuous education or even with the cooperation of other members of the health care team, everyone is able to participate in activities such as public awareness, preventive and mental health actions, developing relationships with the local authorities to promote the psychosocial rehabilitation of the seriously ill, interventions in patients' family, etc. All activities can be covered efficiently, if the employees have been set up accordingly to certain scientific disciplines and its members have the opportunity to undertake additional roles or/and to cooperate with other institutions.

In our time, despite the fact that the concept of community has undergone significant changes and has become quite loose and vague, reference to the community remains significant both in terms of 'belonging' to a certain group and the services provided. The support of the neighbourhood, the municipal authorities and informal institutions facilitate the work of a MHC easier. The collaboration with the community served by the MHC, provides an opportunity for offering services (psychiatric coverage of community institutions such as KAPI, activities relating to the prevention of mental illness and the de-stigmatisation of patients, counselling services etc.) and also obtaining support for the work of a MHC (disposal sites for housing activities, opportunities for employment for patients) and working with informal providers of community services (Kontaxakis et al. 2010). According to WHO, a MHC should seek cooperation with the employees in community projects, alternative therapists, family members, self-help groups, advocacy services and religious leaders who offer information on dealing with traumatic situations and other exceptional events. Particular attention is given to volunteer groups that educate parents and young people on mental health issues and to volunteer groups that provide humanitarian aid in emergency circumstances (WHO 2003).

Necessary is also the continuous effort to improve the quality and organisation of the services provided. Significant is the involvement of the mental health professionals in the process of quality improvement as in this way are more likely to offer correct and realistic solutions to the problems and hence to apply the changes. (WHO 2003).

The role of the Mental Health Centre in the prevention of psychiatric disorders

The Mental Health Centre operates in primary, secondary and tertiary prevention. Its priorities should relate to the quality of mental health services, suicide prevention, early detection and management of mental disorders and rehabilitation and social integration (Fiorilo et al. 2013).

Primary prevention is defined as the detection and elimination of the factors that contribute to the onset of mental disorder. It focuses mainly on the modification of pathogenic behaviour and the detection of high risk populations. These include people unemployed, elderly and alone, deprived and socially marginalised, exposed to stressful events. Also, immigrants, people with serious health problems, troubled or single-parent families, families of addicts, alcoholics, mentally ill, people in the process of retirement, teenagers who have left home and school, etc. It is evident that these categories of people cover a wide range of the population, which cannot be accessed by a small group of specialists, for reasons both ethical (we have no right to invade people's lives, because they are 'at risk' of getting sick) and scientific (it is very difficult to encode specific intervention goals and the necessary epidemiological tools). Excessive exposure to prevention activities can be detrimental to the primary healing process of the unit (Kontaxakis et al. 2010). For these reasons, the objective is broader publicity for attracting high-risk populations, so many of them ask for help. In most countries, social groups that avoid mental health services are men and people with fewer years of education found in both ends of the age and income range (Wang et al. 2007).

A prerequisite for timely intervention at an early stage is the detection and identification of people at risk. A first step in this direction is the creation of information and awareness programmes and programmes to combat the social stigma (Goffman 1963). Particularly in Greece studies have highlighted a serious lack of knowledge of serious mental disorders such as schizophrenia (Economou et al. 2009).

The secondary prevention aims to reduce the prevalence, the time with active symptoms and prevent or delay the relapses. It constitutes, at least quantitatively, the main area of preventive activity of a MHC, and it is closely linked with the therapeutic activity of the unit. The effectiveness of the action depends on a well organised network of referrals (by local social institutions and authorities, primary health services, hospitals, private doctors, etc.), the accessibility of services (geographical but also organisation of the working hours in order to serve a wider social spectrum of residents) and reception capacity (rapid service, ability to assess demands and the urgency or not of their nature). Of particular importance is the possibility of home visits (for groups of patients who are unable or refuse to move) and generally on managing the crisis (both the potential risk assessment and measures that have a positive outlook for the patient). The rapid reception of a request of a patient and his relatives, the early diagnosis, support

and treatment of the patient and possible hospitalisation are the basis of secondary prevention. This type of prevention involves other specialities apart from psychiatry as often mental disorders can manifest themselves in physical symptoms, while a number of physical diseases are likely to occur with symptoms from the mental realm.

Tertiary prevention aims to achieve steady and sustainable improvement of symptoms and the patient's functionality. Exercised both via the current work of the MHC with patients exhibiting major psychopathological problems and the work of psychosocial rehabilitation (structures within the area of responsibility of the MHC) to limit the disease impact on the affected individual, his family and society. Tertiary prevention concerns the actual psychiatric symptoms as the major mental illnesses are in need of concerted efforts at many levels (e.g. pharmacotherapy, clinical monitoring, family support, learning social skills etc.).

The psychosocial rehabilitation was developed, as a special branch of psychiatric care, in the last 20-30 years. Its initial object were inmates in psychiatric institutions and then extended to broader groups of patients with major psychopathological issues. This happened from the moment it became apparent that skilled labour is needed to provide a way out of the stage of development of a mental illness, where remission of active psychopathology is observed, but is dominated by negative symptoms and the resignation of the patient facing various difficulties (Madianos 1994). Long term treatment in a closed psychiatric institution has proven particularly an aggravating factor for the future course of the patients. Even for patients hospitalised for decades, their transfer to psychosocial rehabilitation facilities was found to improve their clinical condition steadily while important changes were observed in autonomy, socialisation, and expression of will without at the same time any deterioration (Furlan et al. 2009). In addition to the effort for shorter hospitalisation, partial hospitalisation (day centres and hospitals day) has proved particularly important as it fulfils multiple needs of the patient without drawbacks of being removed from his usual environment.

Adverse environmental factors such as insufficient support system, social isolation or/and great lack of resources are included within the tertiary prevention. The reduction or elimination of these adverse factors is one of the main objects of labour of psychosocial rehabilitation (Furlan et al. 2009). The strengthening of a patient in social life, family and neighbourhood is necessary as therapeutic and educational efforts still have a chance of success. Additionally, housing in hostels or sheltered flats, for a certain period of time, may be necessary to patients in great conflict with their family while exiting long term hospitalisation orare in search of work.

The occupational rehabilitation of patients requires – alongside the stabilisation of the clinical manifestations of the disease – the coverage of learning gaps and the gradual familiarisation with the working conditions. Often specific working conditions are required (e.g. part-time) and special training of the staff, to accompany the patients on this path. Finally, tertiary prevention aims to reduced self-esteem and discouragement of the patient. Very often patients under the burden of the symptoms and social problems, refrain from personal and social life and are marginalised. If this trend is not reversed other actions become futile. A large part of the clinical work and the psychotherapeutic methods look forward to this reversal (Zissi 2001).

Mental health promotion in the community

The World Health Organization (WHO) defined mental health as a condition for physical health and it defined it as "… a state of wellbeing in which the individual realises his capabilities, is in a position to cope with common stresses of life, can work productively and efficiently, and is able to offer to his social environment" (WHO 2004). But, despite great efforts, the growth rate of new cases could not be adequately controlled. This led the scientific community in search of additional tools and methods for the protection of mental health. The development of the subject of Mental Health Promotion (MHP) is considered today as one of the most significant efforts to limit the increase of mental disorders. This is because it aims not only to combat risk factors but mainly to enhance mental health at individual and public health. This is achieved through the development of individual skills, strengthening individual capacities to address stressful life events, as well as through proper information, education and awareness of the socio-political institutions associated directly or indirectly with mental health (Vassiliadou, 2008; Charalampous et al. 2008). With all the above will be achieved both the enhancement of mental health and the creative treatment of stressful events on a personal level and the creation of appropriate conditions to prevent and combat the factors related with the installation or recurrence of mental disorders (Knapp et al. 2007).

In real conditions it is difficult to be understood as effective an intervention to prevent a disease without simultaneously developing the factors that are positively associated with mental health, so the subject of Mental Health Prevention seems as limited in relation to the subject of Mental Health Promotion (Vassiliadou, 2008). Mental disorders and mental health cannot be described as the different ends of a linear scale, but rather as two

overlapping and interrelated components of a single concept of mental health (Detels et al. 2002). Prevention uses strategies of mental health promotion to achieve its objectives (WHO 2004; Hosman et al., 1999). Therefore, the individual's skills needs to be developed simultaneously (mental health skills), to be able to deal with everyday stresses, but also the potential, psycho-traumatic events, such as natural disasters, deaths of loved ones, serious socio-economic losses, etc., which are often related to the development of mental disorders (Warnke et al. 2010). Investigation of mental health components and mainly the answer to the primary question about "what is it that makes someone to be healthy", is one of the main research objectives of the subject of MHP (Papadimitriou et al. 2013). With the increase of positive mental health, reduction of inequalities and building of social capital, MHP aims to reduce the mental health gap between social groups and countries (WHO 1997). According to WHO effective mental health promotion interventions that can be applied to the community in partnership with the MHC are the following (WHO 2004):

Childhood/ Adolescence

  ¬ School programmes to develop skills in problem solving
  ¬ School holistic interventions that combine building skills and changes in the environment
  ¬ Access to preschool education
  ¬ Cognitive – Behavioural programmes for children at risk of depression
  ¬ Techniques for stress management
  ¬ Social policies for the promotion of social support and inclusion and prevention of social exclusion – Visits at home

Adults

  ¬ Interventions for parents with difficult children
  ¬ Residential visits to depressed mothers
  ¬ Techniques for stress management
  ¬ Brief interventions for alcohol
  ¬ Timely diagnostic interventions
  ¬ Physical exercise - Psychoeducation

Conclusion

The significant burden of mental disorders on personal, family and social level is indisputable and discussions on improving the mental health services are gaining ground amongs leaders. A key issue is the shift of care from institutional situation to the community with the main recipient being the Mental Health Centre. Based on the guiding principles of care for the mentally ill, Mental Health Centres can contribute decisively to the prevention and promotion of mental health and reintegrate patients into society.

References

Charalambous P . , Kleisiaris X . The contribution of health education on mental health: A Literature Review . e-Journal of Science & Technology (e-JST), 2008, 2 (3), 19-32.

Detels R. et al. Oxford textbook of public health. 2002, 3rd ed. Oxford. Oxford University Press.

Donovan CM. Problems of psychiatric practice in community mental health center. American Journal of Psychiatry 1982, 139:456-460.

Economou M. et al. Knowledge About Schizophrenia and Attitudes Towards People with Schizophrenia in Greece. International Journal of Social Psychiatry, 2009, 55, 361.

Fiorilo A. et al. Priorities for mental health research in Europe: a survey among national stakeholders' associations within the ROAMER project. World Psychiatry, 2013, 12, 165–170.

Furlan P.M. et al. Four-year follow-up of long-stay patients settled in the community after closure of Italy's psychiatric hospitals. Psychiatric Services, 2009, 60, 1198−1202.

Gelder M.C, López-Ibor J.J., Andreasen N.. Oxford Textbook of Psychiatry, 2001.

Goffman E. Asylums: Essays on the Social Situation of Mental Patients and Other Inmate. 1961, USA. Anchor Books.

Hosman C. et al. Political challenges 2: mental health. The evidence of health promotion effectiveness: shaping public health in a new Europe. Brussels. International Union for Health Promotion and Education, 1999

Kontaxakis VP, Havaki-Kontaxaki BJ, Christodoulou GN Preventive psychiatry and mental hygiene, 2010, Athens, Beta.

Knapp M. Et al. Mental Health Policy and Practice Across Europe: The Future Direction of Mental Health Care. The European Observatory on Health Systems and Policies. Open University Press, 2007

Madianos GM. Methods to prevent psychopathological problems in the restoration process in the community . In: Madianos M. Psychosocial rehabilitation. Greek Letters, Athens, 1994:21-40.

Madianos GM . The Community Mental Health Centre . Administrative - organizational issues and a Greek model Community Mental Health Center urban type . The first experience in Community Mental Health Center Byron - Kesariani . In : Community Psychiatry and Community Mental Health . Kastaniotis, Athens, 2000:62-80,81-102.

Ministry of Health and Welfare. Guide service organization to tackle the crisis and emergency. Support & Monitoring Unit "Psychargos - Phase B ", 2006, Athens. Ministry of Health .

Ministry of Health and Welfare. "Psychargos C " - Review Draft Psychargos program, 2011, Athens.Ministry of Health.

Papadimitriou GN , Liappas I, Lykouras E . Modern Psychiatry , Athens 2013. Beta .

Sakellaropoulos P. The foundation of psychiatry is the emotional bond therapist - treated, 2010, Athens. Papazisis.

Vassiliadou M. "EPICTETUS": Axiological Cognitive Educational Strategies (ACES), London 2005, Educational Trust for Health Improvement through Cognitive Strategies

Wang P.S. et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. Lancet, 2007,370(9590), 841-50.

Warnke I. et al. Clinical and social risk factors for the readmission of patients with schizophrenia to psychiatric inpatient care: a long-term analysis. Neuropsychiatry, 2010, 24(4),243-51.

World Health Organization. The Jakarta Declaration on leadin health promotion into the 21st century. Geneva, 1997, WHO.

World Health Organization Organization of services for mental health. Geneva. 2003, WHO.

World Health Organization Mental Health Policy and Service Guidance Package Quality Improvement for Mental Health, 2003, Geneva. WHO.

World Health Organization. Prevention of mental disorders: effective interventions and policy options, 2004, Geneva. WHO.

World Health Organization. Mental health declaration for Europe. Copenhagen: World Health Organization. Regional Office for Europe, 2005a, WHO.World Health Organization. Mental health action plan for Europe. Copenhagen: WHO Regional Office for Europe, 2005b, WHO.

Zissi A. Psychosocial Rehabilitation of Individuals with Chronic Mental Health Difficulties:Research Developments and New Perspectives. Encephalos, 2001,38.