The Least Restrictive Option
A driving force in the Development of Community Psychiatry

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Key Words: Mental Health Services, Neurobiology, Human Rights, Community Psychiatry.

ABSTRACT

Here we argue that the development of community psychiatry across a number of nations of Europe is due to the present availability of effective treatments for mental illness, and an increased knowledge of how the brain responds through its plasticity, to both mental illness and its treatment. Furthermore, the development of community psychiatry is the result of the development of an increased understanding of and respect for human rights within the countries of Europe. We describe the system of community psychiatry at present functioning in the UK. As a philosophy of care, community psychiatry can only be justified if we take into account the need to respect the rights of the individual and the need therefore to use the least restrictive (but effective) option in delivering mental health care.

Since the day that Philippe Pinel ordered that the chains be removed from the psychiatric patients at the Salpêtrière Hospital for Insane Women in Paris in 1795, a tension has always existed in psychiatry between a perceived need to restrain patients with mental illness for their own safety and that of others and an overriding need to treat patients who have mental health problems with respect for their human rights. The reality is that worldwide, chains have not entirely disappeared from psychiatry. It is known that chains are still used by families to restrain mentally ill patients in rural India and Pakistan. Perhaps symbolic of the change in mental health treatment to less restrictive methods of management and treatment and hence the change to community psychiatry , which is the subject of this article, is the change from such use of chains in Aceh Provence Indonesia to a community psychiatry system after the Tsunami of Boxing Day 2004. Physical restraint and confinement of the mentally ill (called pasung in Indonesia) is common in Aceh. In 2010, the local government initiated a program called Aceh Free Pasung 2010. The main goal of the program is to release the mentally ill in the province from restraint and to provide appropriate medical treatment and care. As a consequence of the development of a community mental health system as well as the introduction of a health insurance system in Aceh (together with the national health insurance scheme for the poor) both access to free hospital treatment for people with severe mental disorders and treatment in the community has been enabled, including for those patients who had been in pasung (1). Thus in Aceh, the evolution of two centuries of psychiatric care in Europe has developed over a single year.

Indeed, in Europe, from the time of Pinel to the late part of the twentieth century, psychiatric care was delivered in large institutions or mental hospitals, in which were accommodated many thousands of psychiatric beds. This remains the case in many European countries. Often these hospitals had beautiful grounds, and they provided an economic way of caring for the mentally ill at a time when there were few effective treatments for them.
However conditions in these mental hospitals were often overcrowded, and the lack of privacy and institutionalisation did not necessarily always lead to the full recognition of the patients' dignity as a human being (2).

The next move forward in the treatment of mentally ill patients was the discovery of effective medication for the treatment of mental illness, typified by the first use of chlorpromazine in mental illness in 1952 (3) by Laborit, Deniker and Delay (4).

The presence of effective treatments in turn led to, over the 1970's to 2000's to the gradual implementation in many parts of Europe of more and more community based treatments, with reduction in number of bed days spent in hospital, increased treatment in the community, closure of many wards in psychiatric hospitals, and the implementation of a system of community teams to provide support to patients in the community. It simultaneously led to the re-development of the remaining psychiatric wards so that they became more oriented towards recovery from mental illness. The orientation of these wards towards recovery can now, at least in the British system, be audited by such a tool as DREEM, which will demonstrate that a ward treats patients in a way which respects their human rights including such issues as enabling them to express their spirituality (5).

Also contributing to the development of community psychiatry has been the development of the bio-psychosocial Model of mental illness. The discovery of DNA by Watson and Crick has led to the development of an understanding of the genetics of psychotic illness, in particular the idea that mental illness is caused by many genes, each of which has a small effect (6), and it has become increasingly evident how the impact of psychological influences such as childhood adversity affects the brain's response to

stress (7,8) and its plasticity (9), causing an increased propensity to mental illnesses such as depression [10]. Furthermore the development of epigenetics has shown how, and by what mechanisms, the environment impacts on mental illness (11). Hence we now have a much greater understanding than heretofore of the influence that society, psychological factors and the environment have on mental illness. Meanwhile, it has become possible, with the aid of neuroimaging techniques such as MRI, to view the changes which take place in the brain as a result of mental illness (12), and even to begin to stage such illnesses as schizophrenia, much as we can stage cancers, so that treatment of mental illness can be planned and outcomes measured (13,14). MRI also enables changes to morphology caused by medical treatment to be observed (15,16).

Thus, there is now a strong and ever developing scientific underpinning for the development of more community oriented treatments for mental illness, and these are becoming more and more effective.

The teams which are used to manage mental illness in the community are generically known as Community Mental Health Teams.

All of these teams are composed by psychiatrists, nurses (Community Psychiatric Nurses), social workers, occupational therapists, psychologists, and are lead by a consultant [senior] psychiatrist.
It is of great importance that the teams work in conjunction with the patient's general practitioner. Indeed, there is evidence that, where effective shared care protocols are in place with general practitioners, the outcomes of treatment of such illnesses as depression are significantly improved (17,18).

Within the British system, a number of different community psychiatric teams are described. Each of these teams are 'interlocked' with the others so as to produce a complete service. The teams include : Community Mental Health Teams, Crisis and Home Treatment Teams, Assertive Outreach Teams, Early Intervention in Psychosis Teams.

Community Mental Health Teams
The Community Mental Health Teams [CMHT] are staffed by psychiatrists, nurses, social workers, occupational therapists , clinical psychologists and others. They cover a locality or catchment area in a particular location. They were the first teams to be set up, and are still the mainstay of community mental health services. They now are devised into two sub-teams for greater efficiency, one of which is concerned with the assessment of patients , while the other sub-team continues to work with patients in the medium to long term in such a way as to facilitate recovery from mental health problems. They take all cases of moderate-severe severity, and take patients in the medium to long term. The case load per staff member should be about 30 each. One issue with community mental health teams is that they do tend to discharge patients back to their general practitioners if they do not attend. CMHTs may use brokerage case management.

Crisis Resolution and Home Treatment Team
The Crisis Resolution Team [CRT] is for adults with severe mental Illness who are in crisis, and would otherwise require hospitalisation. The illnesses dealt with include: schizophrenia/ other psychoses, depression and bipolar affective disorder. The CRT offers the patient home treatment and follows the patient up for 6 weeks. The patient is then referred on to an appropriate team for longer term follow up or discharged.

The Crisis Resolution Team is aiming to achieve treatment in least restrictive environment, with minimum disruption to patient's life. It works in a range of settings, including having access to 'crisis beds', for very short term assessment and treatment if this is necessary . The Crisis Resolution Team acts as a 'gatekeeper' to mental health services. It provides immediate community based treatment 24 hours a day, 7 days a week. It remains involved till the crisis is resolved and the patient is linked with ongoing care. If patient is admitted to hospital, the Crisis Team may help with discharge planning and early discharge.

The Crisis Resolution Team aims to reduce patients' vulnerability to crisis and to maximise resilience.
Home treatment is used because people like to be treated at home. This particularly refers to ethnic minorities like South Asians. Furthermore, if the only treatment is an antipsychotic or an antidepressant and regular benzodiazepines, it may not be necessary to admit to hospital, provided appropriate supervision can be given and the home environment has ben assessed so as to be sure home treatment is safe and effective.

A home treatment team should deliver a model of care which includes providing a designated named worker for each patient, offering intensive support with frequent contact and visits, as well as ongoing risk assessment and assessment of needs . It should work assertively. It should offer appropriate medication, practical help with daily living, including benefits, psychological interventions including problem solving, stress management and counselling. It should improve the patient's social networks, and work with families or carers. It should offer psycho-education to both patients and their carers, and should implement relapse prevention, by helping patients identify early signs of relapse, and sharing the relapse prevention plan with the patient, general practitioner, carers and family. Finally it should be able to, where necessary, offer respite care using appropriate beds and work with inpatient services and other teams (19).

Assertive Outreach Team

An assertive outreach team is for patients with serious mental illness - usually chronic, e.g. schizophrenia or bipolar affective illness or borderline personality disorder. These patients will have a high level of disability, and are usually difficult to engage with.
They include patients who are frequent relapsers, and are frequently admitted to hospital. They also include patients with complex needs, including violence, persistent offending, persistent self harm, neglect, poor response to treatment, dual diagnosis of substance misuse and serious mental illness, having been detained under the mental health act, having unstable accommodation or homelessness. Any combination of these situations may make the patient appropriate for the assertive outreach team.
An assertive outreach team should be able to deliver the development of meaningful engagement with patients, and provide evidence-based interventions to promote recovery. It should increase stability within the patients' lives, facilitate personal growth and provide opportunities for personal fulfilment. It should provide a service that is sensitive and responsive to service users' cultural, religious and gender needs. It should support the patient and his/her family/carers for sustained periods. It should promote effective interagency working, and ensure effective risk assessment and management.
Working assertively means working assertively with patients 'as you find them, where they are'. It means assessing patients needs, and offering to help them with those needs, and meaning it, so that the patient can have confidence in the team. It means not giving up on people. It means not discharging people if they do not attend, but instead finding out why they have not done so (they may be relapsing).
It means being willing to meet people where they want to meet - the shops, a pub, the football ground, etc. It means keeping plugging your message, but not aggressively. Working assertively as a method is

common to crisis intervention, early intervention and assertive outreach teams. To achieve this, the staff must have a limited caseload - 12 each as a maximum.

The principles of care on which assertive outreach is based are that the team is self-contained, responsible for providing the full range of interventions, that it includes a single responsible medical officer who is an active member of the team, that treatment is provided on a long-term basis with an emphasis on continuity of care, that the majority of services are delivered in community, that the emphasis is on maintaining contact with service users and building relationships, that care co-ordination is provided by the assertive outreach team, and that the individual members of the team have a small caseload.
An assertive outreach team should deliver the following interventions:

- A team approach, being age, culture and gender sensitive, offering regular review,
- Working assertively, offering frequent contact, offering help with basic daily living, including skills, offering appropriate medication, and ensuring that decisions on medication include the patient,
- Offering psychological interventions, including CBT,
- Working with families/carers to give support and understanding of the illness, by offering psycho-education,
- Treating co-morbidities, offering social intervention to reduce isolation,
- Attending to the patient's physical health,
- Helping the patient to access educational and employment opportunities, preventing relapse by showing the patient how to identify early signs of relapse,
- And finally working effectively with Crisis intervention and inpatient teams (19).

Early Intervention in Psychosis Team

An Early intervention in psychosis team is an assertive team which works specifically for three years with patients who have a first episode of psychosis. It works on the assertive model with these patients for three years in order to attempt to optimise treatment outcomes in these young people.
The Early Intervention team is attempting to reduce stigma, raise awareness of psychosis, reduce delay, engage meaningfully with patients, intervene effectively, and promote recovery.
It is useful to have specific teams for these patients because the age of onset of psychosis coincides with a critical period in the patients' life for education, training, employment, sexual relationships, leaving home and starting their own family.

In order to achieve this, an early intervention team will follow the guidelines bescribed below (19,20,21):

- \- A strategy for early detection and assessment of frank psychosis is an essential component of early intervention.
- \- Following referral of a case, a key worker should be appointed soon, in order to engage with the client and family / friends through the first three years (the critical period) within a model of assertive case engagement.
- \- An assessment plan and a collaborative assessment of needs, which is both comprehensive and collaborative, and driven by the needs and preferences of the client and their relatives and friends should be drawn up.
- \- The management of acute psychosis should include low dose, preferably atypical antipsychotics and the structured implementation of cognitive therapy.
- \- Family and friends should be actively involved in the engagement, assessment, treatment and recovery process.

- - A strategy for relapse prevention and to counter treatment resistance should be implemented.
- - A strategy to facilitate the client's return to work and valued occupation should be developed within the critical period.
- - It should be ensured that the basic needs of daily living - housing, money and practical support are met.
- - Assessment and treatment for co-morbidity should be undertaken and the team should ensure that a local strategy to promote a positive image for people with psychosis is adopted.
- We have been able to demonstrate that such an Early Intervention Team does produce better outcomes in the treatment of first episode psychosis than treatment as usual, thus justifying the assertive approach (22). Once a less assertive approach is adopted, after three years, our results show that the benefits are lost (23), but at least one study suggests that if the assertive approach is maintained after five years, the improved outcomes are maintained (24). One consequence of this is that it seems likely that it is the assertive care provided by care co-ordinators from community teams which is crucial to the outcome of the management of psychotic patients in the community (25).

The key to mental health treatment in the community is care planning. Care Planning in the UK is referred to as the Care Plan Approach (CPA). For each patient, the care-coordinator carries out a full assessment of the risks which the patient poses, and of the patient's needs. The care-coordinator will then draw up a care-plan , which will detail all the care which the patient will receive, and who will provide the care. This plan will be agreed at a meeting which will be attended by the patient, the family, the care-coordinator, the psychiatrist, the general practitioner (if he is available), and other team members who will provide some of the care.

The plan will be agreed collaboratively with the patient and the family. It will be signed by all parties concerned, including the psychiatrist. The plan will be reviewed at a formal meeting of those concerned. Such a meeting will be held every six months or more frequently if necessary. All parties will be given a copy of the care plan. This system is essential to the smooth and safe delivery of care.

In Slovenia, a small pilot Community Team, working on an assertive model has been trained and is working in Ljubljana. There is also a team in Maribor. Both these teams have visited the UK as part of their training (26).

One hopes that there will be further development along these lines. However, although Community Mental Health Teams are very useful in the development of psychiatry, they are a very costly human resource. Therefore in order for a nation to embrace the commitment to provide its people with community mental health services, it is necessary that it be understood that the prime motivation for doing this is not the saving of money by closing large outmoded hospitals, but the provision to the people of mental health services which respect their rights and dignity, indeed the application of the principle in mental health of choosing, when dealing with patients, the least restrictive option.

References:

1. *Ibrahim P, Marthoenis M, Minas H. Aceh Free Pasung: Releasing the mentally ill from physical restraint. International Journal of Mental Health Systems 2011, 5:10*
2. *Bentall, R. P. (2003) Madness Explained: Psychosis and Human Nature London: Penguin Books Ltd. ISBN 0-7139-9249-2*
3. *López-Muñoz F, Cecilio A, Cuenca E, Shen W W, Clervoy P, Rubio G. History of the discovery and clinical introduction of chlorpromazine. Annals of Clinical Psychiatry 2005; 17 (3): 113–35.*
4. *Turner T. Chlorpromazine: unlocking psychosis. BMJ 2007; 334 (Suppl 1): s7*
5. *Bhui K et al Outcomes Compendium. National Institute for Mental Health in England. 2008.*
6. *Craddock N, Owen MJ. The beginning of the end for the Kraepelinian dichotomy. Br J Psychiatry. 2005 ;186:364-6*
7. *Goh C, Agius M. The stress-vulnerability model how does stress impact on mental illness at the level of the brain and what are theconsequences? Psychiatr Danub. 2010 ;22(2):198-202*
8. *Frodl T, O'Keane V. How does the brain deal with cumulative stress? A review with focus on developmental stress, HPA axis function and hippocampal structure in humans. Neurobiol Dis. 2012 Mar 9.*
9. *O'Keane V, Frodl T, Dinan TG. A review of Atypical depression in relation to the course of depression and changes in HPA axis organization. Psychoneuroendocrinology. 2012; 37(10):1589-99.*
10. *Carballedo A, Lisiecka D, Fagan A, Saleh K, Ferguson Y, Connolly G, Meaney J, Frodl T. Early life adversity is associated with brain changes in subjects at family risk for depression. World J Biol Psychiatry. 2012 Apr 20.*
11. *Pregelj P. Gene environment interactions in bipolar disorder. Psychiatr Danub. 2011 ;23 Suppl 1:S91-3.*
12. *Koutsouleris N, Schmitt GJ, Gaser C, Bottlender R, Scheuerecker J, McGuire P, Burgermeister B, Born C, Reiser M, Möller HJ, Meisenzahl EM. Neuroanatomical correlates of different vulnerability states for psychosis and their clinical outcomes. Br J Psychiatry. 2009 ;195(3):218-26*
13. *Agius M, Goh C, Ulhaq S, McGorry P. The staging model in schizophrenia, and its clinical implications. Psychiatr Danub. 2010 ;22(2):211-20.*
14. *Agius M: Outcome Measures in Psychiatry. Psychiatr Danub. 2010 ;22 supp 1 ; 38-41*
15. *Lieberman JA, Tollefson GD, Charles C, Zipursky R, Sharma T, Kahn RS, Keefe RS, Green AI, Gur RE, McEvoy J, Perkins D, Hamer RM, Gu H, Tohen M; HGDH Study Group. Antipsychotic drug effects on brain morphology in first-episode psychosis. Arch Gen Psychiatry. 2005 ;62(4):361-70*
16. *Vermetten E, Vythilingam M, Southwick SM, Charney DS, Bremner JD. Long-term treatment with paroxetine increases verbal declarative memory and hippocampal volume in posttraumatic stress disorder. Biol Psychiatry. 2003;54:693-702.*
17. *Agius M, Murphy CL & Zaman R: Does Shared Care help in the treatment of Depression? Psychiatr Danub. 2010 ;22 supp 1 ; 18-22.*
18. *Simon GE, Katon WJ, VonKorff M, Unützer J, Lin EH, Walker EA, Bush T, Rutter C, Ludman E. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. Am J Psychiatry. 2001 ;158(10):1638-44.*
19. *Department of Health Policy implementation guide 2001.*
20. *IRIS Guidelines North Birmingham Trust 1999.*
21. *Agius M, Shah S, Ramkisson R, Murphy S, Zaman R. An Early Intervention for Psychosis Service as compared with Treatment as Usual for First Psychotic Episodes in a standard Community Mental Health Team; Basic Concepts and the Service. Psychiatria Danubina 2007, 19; 5–9.*

22. *Agius M, Shah S, Ramkisson R, Murphy S, Zaman R. Three year outcomes of an Early Intervention For Psychosis Service as compared with treatment as usual for first psychotic episodes in a standard Community Mental Health Team - Final Results. Psychiatria Danubina 2007; 19;130-138.*
23. *Agius M, Hadjinicolaou AV, Ramkisson R, Shah S, Ul Haq S, Tomenson B, Zaman R. Does Early Intervention for Psychosis Work? An analysis of Outcomes of Early Intervention in Psychosis based on the Critical Period Hypothesis, Measured by Number of Admissions and Bed Days Used over a period of Six Years, the first three in an Early Intervention Service, The second Three in a Community Mental Health Team. Psychiatr Danub. 2010 ;22 supp 1 ; 63-67*
24. *Zaytseva Y, Gurovich IY, Shmukler A. Effectiveness of the integrated long-term program of management of patients after first psychotic episode in 5-year follow-up. Psychiatr Danub. 2010 ;22 Suppl 1:S92-4*
25. *Friis S. Early specialised treatment for first-episode psychosis: does it make a difference? The British Journal of Psychiatry 2010 ;196, 339–340*
26. *Agius M, Furlan M, Bulic I, Zmuc L, Zajelda B, Susnik V, Jeric A. The development of a Leonardo Program for teaching Community Psychiatry. Psychiatria Danubina 2006; 18; 193-199.*