EUCOMS NETWORK
NEWSLETTER

EUROPEAN COMMUNITY BASED MENTAL HEALTH SERVICE PROVIDERS NETWORK

THE LATEST NEWS, VIEWS, AND ANNOUNCEMENTS MAY 2022

ASSOCIATION OF PEER EXPERTS IN CROATIA AND DECADES OF ACT IN ASTURIAS, SPAIN

TWO PIONEERS OF COMMUNITY MENTAL HEALTH IN CROATIA AND SPAIN TELL THEIR STORY

First we go to Croatia. Vlatka Ročić Petak, is a Professor of Sociology, expert by experience, and founder and president of Ludruga, the 'Madnessociation' in Croatia (www.ludruga.hr/en).

I met her in Zagreb when I was involved in a mental health reform project there and was impressed by the way they conduct peer support groups and a mobile peer team for psychosocial support in the community where peers and mental health professionals currently work. She describes it in more detail in her article.

Then we go to Spain. In Asturias, Northern Spain, they introduced Assertive Community Treatment already in the '90's , in the cities of Aviles, Oviedo and Gijon. From the beginning, the psychiatrist Juanjo Jambrina was involved. This made Aviles a hub of community mental health in Spain. I visited 2 of their national meetings and in 2013 they hosted the congress of the European Assertive Outreach Foundation https://eaof.org. EUCOMS and EAOF are strongly connected. Juanjo Jambrina tells us about the vision and development in Asturias in his article.

Both authors are members of the board of EUCOMS. Do you want to share your successes, struggles or both on the development of community mental health in your region? Please contact us via info@eucoms.net. Our newsletter is there to share and lean for each other!

Rene Keet, chair of EUCOMS
May 2022

Recovery model in providing peer support to people with mental health difficulties during the challenge of pandemic isolation

Ludruga Association – Madnessociation

What you will read about in the following lines is the implementation of the recovery model by providing peer support on the example of the Croatian association Ludruga (Madnessociation) www.ludruga.hr/en.

Ludruga was founded on the need for personal affirmation of people who have experienced mental health problems and are easily and unrightfully declared disabled as well as the need to show that there is so much to give exactly because of that experience.

There was a desire to initiate a process of strengthening people within the community by creating peer support (a mutual support of equals) network.
Consequently, the first support group meetings took place in September 2012, and since that day they have been continuously held until the present.

Members of the association have been helping people with mental health problems and their families by applying the principle of peer work and collaboration with mental health professionals who respect the principle of work based on equality and equal opportunity.

In the Ludruga Association, we continuously conduct peer support groups; we have established a mobile peer team for psychosocial support in the community where peers and mental health professionals currently work.

There are also professional consultations and supervisions for peer workers in the mobile team and individual and group psychotherapy workshops.
The goal is a „tailor-made therapy for the individual".

Peer Support Specialist

This is the basis of the recovery model in providing peer support to people with mental health difficulties.

Participants in the activities of the Ludruga Association are people with an experience in psychiatric treatments, as well as their companions and allies (family members, partners, and friends), and also various professionals (therapists, healthcare professionals, social workers, lawyers, activists of civil society organizations with experience of working in the field of human rights).
Because Peer Specialists are a relatively new phenomenon in mental health systems, definitions differ.

In general, we can clarify the term „Peer Specialist" as a person with lived experience in mental illness or co-occurring disorder who has received specific training to support and help others in their recovery process.

Recovery is the basis of the work of Peer Specialists. It focuses on strength, individual courage, self-esteem, problem-solving skills, coping mechanisms, therapy, and hope. Transformation allows a person with a mental health problem to live a meaningful life in the community of their choice, striving to reach their full potential.

What is important, regardless of the function, is that the Peer Specialist uses his own recovery experience as a means of inspiring others.

Theory and examples show how expertise gained from personal experience can be used in the most effective way to benefit and in relation to the people Peer Specialists work with.

As a Peer worker, you are personally the 'instrument' you work with. It is a powerful and effective tool if you are aware of how to use it.

The challenge of the pandemic isolation

The impact of global change, like the COVID-19 pandemic on the small human individual is unquestionable. The best way to understand their thoughts and inner turmoil is to listen to them. How we live our lives during the pandemic, how it affects our mental health, and what helps us and what doesn't help us to deal with these challenges, find out in the answers of the members of our association:

A1: I suddenly realized that I have more time for things I didn't have time to do before. I read books and watched movies I had always wanted to read and watch. Before there was always something more important to do. I walk a lot more than before. I find it helps me clear my head and sort out my thoughts.

A2: Got divorced during the pandemic after 30 years of marriage. The pandemic affected the lifestyle changes within my family. The problems in our relationships that existed before have now surfaced and become so obvious. Divorce would have happened anyway, the pandemic just hurried it along and I am now facing loneliness. I would benefit from hanging out, meeting new people, going to an exhibition, to the cinema or a museum. All this is now difficult for me to do due to the pandemic.

A3: For me, the opportunity to work from home is the best thing that happened to me thanks to the pandemic. I have more free time to organize myself, more time to cook something healthy, family members see me doing professional duties and see what my job actually entails. Because of that they respect me more and understand me better.

A4: I find it difficult to work from home. In the apartment where I live with my family, I do not have enough privacy for such type of work. I miss going to work and hanging out with colleagues. Contact with older family members who live far away is very difficult for me because they do not use modern technologies. I believe that no technology can replace personal human contact.

A5: I am divorced, I live alone, I have a daughter that I love endlessly, who has been living in the UK for years. In the middle of the pandemic and lockdown in Zagreb, an earthquake happened after which my apartment was not fit for living. For most of the year, I lived with friends who are members of the association. Together we laughed, cried, talked, and listened to what we had to say, worked on projects for the association, worked on the renovation of my apartment, and were there for each other. Being surrounded by such friends is a real blessing. Thanks to that I felt safe, accepted, loved, and it helped me cope with objectively difficult circumstances. Both the pandemic and the earthquake pulled the strength out of me that I was unaware of.

Conclusions

The experience of suffering, which we like to call mental illness, has taught us that we will be alright only if we do not become alienated from each other. That is why our association is playing a very important role during the pandemic for all its members and beyond. The isolation imposed on us by Covid-19 is dangerous for mental health and that is why we regularly maintain Peer support groups, mobile team interventions, consultations, and supervision for team members as well as psychotherapy groups and individual psychotherapy. When epidemiological measures allow us we meet face to face.

Over time, we have become accustomed to encounters in the virtual world. In addition to groups, consultations, and interventions, we also use it for socializing over coffee. The members formed a WhatsApp group for mutual support on their own initiative. It matters a lot to all of us to feel that we are not alone, that we can always talk to someone. With members who don't have access to the internet, smartphones, or laptops we talk on the phone.

We take care of each other, and when it is necessary to bring food, medications, or something else to one of the members, we organize a home visit. This helps us maintain our mental health as well.

At the moment, we are not yet aware of the consequences that the reaction to the pandemic has on the common good, mental health, and human rights. They are constantly telling us that we must adhere to imposed measures to relieve the health care system and save it from collapse. What does that mean? Do we need to feel guilty if we end up in the hospital? The lack of adequate mental health care for all of us creates an atmosphere of great distrust in the system.
Therefore the recovery model in providing peer support to people with mental health difficulties is very important. That is why the work of our association and the development of the Peer Specialists system is essential, both in everyday life and in emergencies such as this one.

Vlatka Ročić Petak
Professor of Sociology, expert by experience, president of Madnessociation

What about Community Psychiatry?

The philosophy of psychiatric reform put forward in the early 70s was supported by some key principles of community psychiatry.
These includes the provision in the mental health care system of : i) out- patient clinics; ii) community mental health teams; iii) acute in-patient care in the general hospital; iv) long-term residential care in the community; v) community services capable of providing rehabilitation, occupational therapy and help with employment.
However, in most high-income countries the psychiatric reform appears to have lost impulse over the years and after achieving the closure of a significant number of psychiatric hospitals the process has not been completed.

The future of Community Psychiatry

This growth of specific services has not been accompanied by a sufficient implementation of additional community, and specialized acute in-patient, services for the intensive care of serious and acute mental illness.

As a result, most western countries have currently insufficient and fragmented community services and the acute care for the severe mentally ill is still provided by traditional in-patient services, placed in psychiatric and general hospital settings.

- This situation was described by Sumathipala and Hanwella many years ago (1996).
- They described what they called a "spiral of community care". This was derived from evidence over a long time period that society alternates between embracing community psychiatry as an inclusive and positive way of treating the mentally ill, and exclusive psychiatry at other times, when those with mental illness are perceived as problematic…

The overload and ossification of the current community model compromises the attention to people with most severe Mental Illnesses. Mainly because the system reduces the time of contact with the patient.

The reality: community interventions, especially at patient´s homes are a privileged place to treat people with severe mental illness (smi) because learning is easier and users needs are best evaluated.

- In the last years, new models of care have been proposed in an attempt to fulfill this important gap in the provision of care for severely ill patients.

The most important of these community alternatives are: Assertive Outreach Care ACT, FACT, Avilés Model and Home Acute Care oriented to Crisis Resolution Treatment (CRT)-teams.

Assertive outreach interventions

Assertive community treatment(ACT) was first developed in the USA in the 1970s as a form of community-based comprehensive care for people with severe mental illness,
In spite of its successful implementation in other countries, a series of studies in the UK indicated that contextual and organizational factors had a great impact on the outcome of ACT, thus providing grounds for introducing changes, which resulted in the configuration of the Assertive Outreach Care (AOC).

This way, the model of treatment implemented more widely in Europe - Assertive Outreach Care (AOC) - is slightly different in its practical elements; i.e. AOC teams do not have to have vocational experts or dual diagnosis experts on the staff, nor provide 24-hour care, nor to have a limit of 1 to 12-15 cases per professional.

We have to stress that despite these differences, the different models share the same principles and key elements of care (FACT, Avilés Model ofACT, etc).
Some of the key elements responsible for the improvement are:

Following a pro-active approach to the follow-up of patients; maintaining daily supervision of the pharmacological treatment; stressing the focus on the care of patients who presented more frequent admissions and a higher risk of relapses and illness complications, and;

Paying special attention to team coordination and especially to the interactions and communication between team members.

The key features that may be mediating the effectiveness of AOT may be: a smaller caseload of patients per professional, mainly nurses (between 15 and 20 patients); a high percentage of clinical contacts at home; to assume responsibility for both health and social care, and; the implementation of a multidisciplinary team approach with a psychiatrist integrated in the team.

Crisis resolution teams

Crisis Resolution Teams (CRTs) are multidisciplinary teams which aim to:

•Assess all patients being considered for acute psychiatric admission;

•Wherever possible, provide a brief, intensive home treatment as an alternative to admission;

•Facilitate early discharge from acute wards through the provision of intensive home treatment.

Differences between CRTS and ACT

CRT and ACT teams both offer intensive, multi-disciplinary, home base treatment.

CRTs:
•Provide brief periods of support;
•Work with anyone in a mental health crisis, not just severe and enduring mentally ill.

CRT teams rarely work with ACT patients.
Reasons for developing crisis resolution teams:

- Therapeutic relationships stronger and more equal on patients' home ground;
- Social networks can be mobilized more effectively;
- Working in the community makes social triggers to the crisis more visible;
- Skills learnt for coping with the crisis may be more sustainable.

Bed costs/day in Avilés, Spain

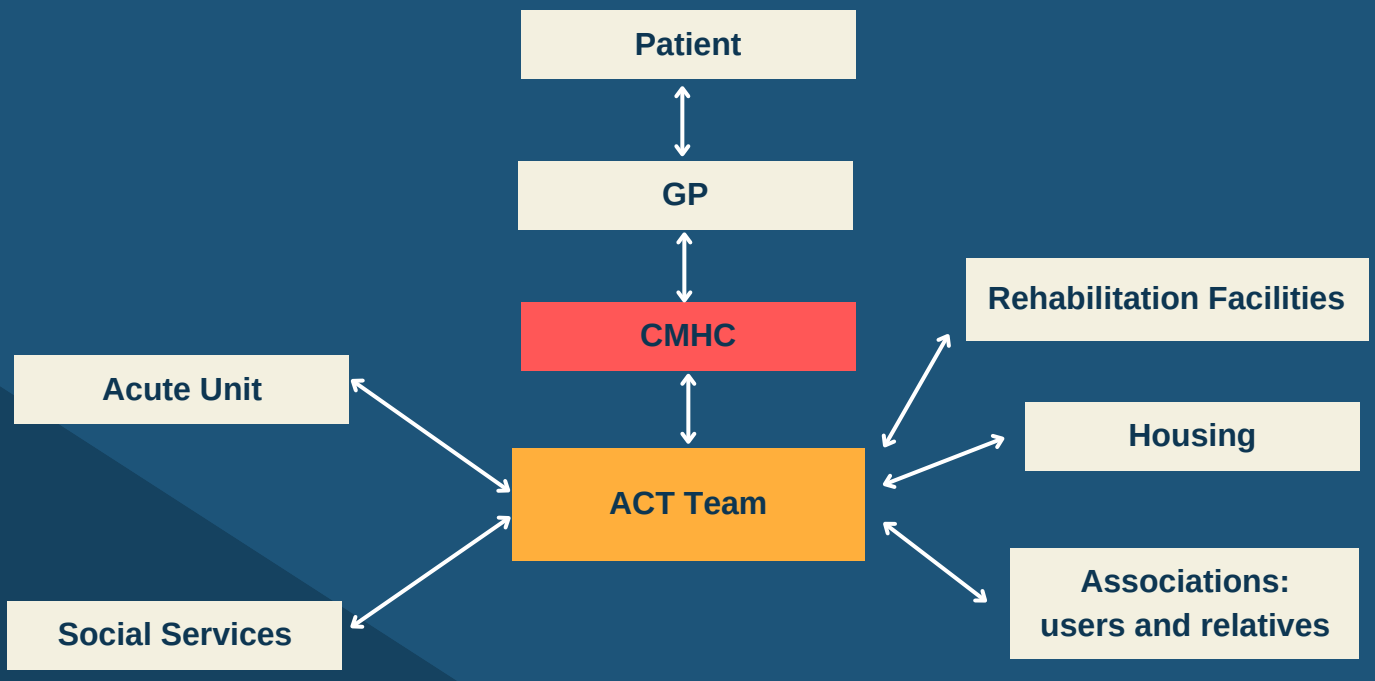
- General hospital : 400 euros/day
- Psychiatric hospital acute unit: 354 euros/day
- Long term care: 262 euros/day
- Attention ACT or CRT : 20 euros/day
- Nowadays, in Spain 60 act teams have been developed. Last years, we have begun working with ACT for youth.

Avilés ACT team

First act team in spain (1999)
Our facilities in 1999 adressed to 150.000 inhabitants.

- 2 CMHC adults
- 1 CMHC Youth
- Addictions Unit
- Acute Unit (16 beds in GH)
- Day Hospital (40 people)
- Therapeutic Community (18 beds)
- 105 professionals

Act Team In The Mental Health Service



Our experience in Avilés

• ACT model is better than Case Management approach. Team Approach!
• About Ethical issues: Assertive or coercion? Care or control?

"Our experience teaches us that the road to independence is through a period of healthy and supportive dependency. After all, we all became adults by slowly gaining our independence from our parents."
(Burns T & Firn M 2002).
"We talk about development, not about envelopment".

• ACT teams are especially useful for people suffering from schizophrenia or bipolar disorders.

AVILES ACT TEAM DATA (1999-2019)	
Admissions	256
Nowadays	111
Patients' age (mean)	47,9 years old
Main relatives' age (mean)	65,7 years old
Living alone	28 patients

Conclusions

• There is a dangerous "care gap" in assistance to people with SMI (Pathare, Brazinova, Levav, 2018)
• There are serious difficulties in measuring the unmet needs of these patients... Home Interventions are so important....
• If this situation continues, the gap will increase and the most severe will be worse served.
• We must implement mental health services with all the resources described above or we will return to ASYLUM. But perhaps now, a new total institution will escape to the reach of psychiatry and will be impossible to dismantle.

Juan José Martínez Jambrina
MD, PhD Head of Mental Health Services,
Avilés, Asturias

Our Future Webinars

REFORM OF MENTAL HEALTH CARE IN POLAND

8 JUNE 19:00 - 20:30 CET

MODELS OF CARE

27 SEPTEMBER 19:00 - 20:30 CET

CLICK HERE TO REVIEW THE PREVIOUS WEBINARS

OUR PARTNERS' EVENTS

WEBINAR: WORKING WITH EXPERIENTIAL KNOWLEDGE IN MENTAL HEALTH CARE

31 MAY | 15:00 - 17:00 CET

WEBINAR - ROLE OF PEER WORK IN THE MENTAL HEALTH FIELD

16 JUNE | 16:30 - 18:00 CET

DO YOU WANT TO BECOME A PARTNER?

That is possible! Becoming a partner or collaborator is open for individuals and organisations that provide or support services for people affected by mental illness. For more information and to register please click the link below.

CLICK TO SUBSCRIBE TO OUR EMAIL NEWSLETTER

CLICK TO JOIN OUR NETWORK

Find us on social media:

Our mailing address is:
info@eucoms.net