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...
emphasis on supported employment, peer support or consumer-operated services, an increasing emphasis on trauma-informed care, and the growing use of psychosocial 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.