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Community mental health in the new millennium*

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Summary: The paper outlines weaknesses and inconsistencies in caring for the mentally ill in the United States. The author suggests that the mental health professionals seek public support for the empirically tested treatment approaches without relying on rhetorical claims and overly optimistic predictions.

Key words: Community Treatment

Gerald Caplan, one of pioneers of the community mental health movement cautioned us against placing too much emphasis on mid-range planning, which assumes that attitudes and interests of the politicians and the public will stay relatively constant [1]. Within a broader historical perspective, the treatment of the mentally ill in America in nearly four centuries offers a sobering example of cyclical alternations between enthusiastic optimism and fatalistic pessimism. The mentally ill have been both the subject of our compassion, sympathy and assistance, and also of our fears, disgust and rejection. Developments in psychiatric treatments and services don't follow the logic of the scientific research. They have been marked instead by the rhetorical claims and unrealistic expectations, which have little basis in facts. For example, the American psychiatric hospitals in 1830s' and 1840s' reported that 90% of new cases were cured when treated promptly [2]. In order to generate public support, the changing mental health paradigms have often been constructed in language which contrasts their positive vision with "the evil of the past." For example, the Community Mental Movement of the 1960s' and 1970s' called for the liberation of the mentally ill from the custody of the psychiatric hospital. The empirical evidence for the efficacy of the community treatment was very limited at that time.

In contrast, during the past 20 years there has been an explosion of well designed research assessing on the effects of community-based treatments for schizophrenia and other severe mental illnesses. There is now an emerging body of evidence dem-

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onstrating that community interventions can improve the long-term outcome of these conditions. These studies demonstrate promises of specific community modalities such as assertive case management, social skills training, cognitive interventions, family education or supported employment [3]. Clinicians should also be cautioned against unwarranted applications and generalizations of these community interventions. For example, before traditional vocational workshops are completely phased out, it would be worth knowing how new supported employment programs assist the severely mentally disabled in maintaining competitive jobs [4].

Clinicians and mental health advocates frequently complain about lack of political support for the causes of the mentally ill. The general public is frequently blamed for its' ignorance and prejudice. Mass media are blamed for stereotyping the mentally ill as violent and unpredictable. But the mental health profession is also responsible in part for creating some public confusion and distrust in various ways. Some of our own historical problems include:

1. Dramatically changing views of serious mental illness in a relatively short historical perspective (from psychodynamic concepts in mid 50s' to the contemporary biological reductionism);
2. Claiming the scientific basis of various highly coercive therapies which were used both as treatment modalities and punishments (from cold showers to insulin shocks)
3. Historical inability to reconcile our social control functions (namely protection of the public) with our aspirations to act as the healers and advocates for the seriously mentally ill;
4. Relating to patients both as individuals lacking good judgment to make independent decisions and as citizens with the right of self-determination.

Another potential damage for the credibility of the mental health profession is our uncritical acceptance of the vocabulary of the contemporary health industry. This Orwellian politically correct language offers a distorted view of our relationships with patients. We may call ourselves "service providers" but we don't really provide a market of choice for the patients, especially when they are brought by the police to hospital emergency rooms. We my call them "consumers" but they don't really have the buying power of ordinary consumers [5].

Accountability for the public money is an important aspect of our professional credibility. While seeking cost-effective treatments is a virtue, we have also learned over and over again that a quick fix in caring for persons with persistent psychiatric disabilities leads to the "revolving door syndrome." Biological therapies, including medication management and psychosocial treatment modalities generally work as long as they are applied. While striving to choose well defined treatment outcomes is a virtue for the profession which has been historically rather vague in describing its own healing power, planning for the future will always involve a choice of social values. We can give in further and further to the economic pressure for the cost containment to become "gate keepers" of mental institutions. Or, we may attempt to convince the public that the persons with severe psychiatric disabilities may gradually improve their

quality of life when they are provided with continued skills training, social support and a long-term case management within their natural living environment [4]. This may not be necessarily an inexpensive proposition for the mental health planners, at least in the short run, but it is the right thing to do.

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