Improving Community Mental Health Services: The Need for a Paradigm Shift

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Abstract

Background: It is now over half a century since community care was introduced in the wake of the closure of the old asylum system. This paper considers whether mental health services, regardless of location, can be genuinely effective and humane without a fundamental paradigm shift.

Data: A summary of research on the validity and effectiveness of current mental health treatment approaches is presented.

Limitations: The scope of the topic was too broad to facilitate a systematic review or meta-analyses, although reviews with more narrow foci are cited.

Conclusions: The move to community care failed to facilitate a more psychosocial, recovery-focused approach, instead exporting the medical model and its technologies, often accompanied by coercion, into a far broader domain than the hospital. There are, however, some encouraging signs that the long overdue paradigm shift may be getting closer.

Improving Community Mental Health Services: The Need for a Paradigm Shift

Western psychiatry is increasingly reported to be in a state of crisis,[1] with challenges that include a poor reputation among other medical disciplines,[2] a perceived lack of scientific status,[3] diminishing confidence in the reliability and validity of diagnostic classifications,[4] and growing concerns around the safety and effectiveness of psychiatric medications.[5] In this respect, a systematic review of 503 studies examining perceptions of psychiatry, psychiatrists, and psychiatric treatments and institutions found pervasive negative attitudes amongst the general public, medical students, the media, other healthcare professionals, and patients and family members.[6] Indeed, the 2008-2011 Action Plan of the World Psychiatric Association was obliged to incorporate specific goals for enhancing the discipline's image.[7]

What factors might contribute to making psychiatric healthcare so uniquely critiqued and polarizing compared to other medical disciplines? This article considers a specific aspect of provision – community care (CC) – and examines the influence of current paradigms in creating and maintaining these kinds of discontent. We suggest that fundamental changes are required in order to develop evidence-based services that are capable of responding to patients' needs in humane and effective ways, and outline examples of approaches that are equipped to institute the necessary paradigm shift in both academic theory and therapeutic practice.

A Brief History of Community Care

Community care usually refers to the delivery of specialist support and treatment in domiciliary settings, and is primarily organized via services like outpatient clinics, supported housing, day services, and the assignment of community psychiatric nurses and social

workers. In western countries, the shift from institutional to CC occurred with the widespread closure of the asylums in the 1950s and 60s, and represented one of the most substantial policy changes in the history of mental health services. The main rationales offered for CC at the time, and since, were increasing access to better care; improving social integration; and eradicating the institutionalization, abuse and neglect that characterized many of the old-fashioned hospitals. Others have pointed out, however, that a major impetus was simply to save money.[8]

While deinstituionalizaton appeared to present a new and less pessimistic approach, what occurred in reality was the exporting of the same 'medical model' rationale that underscored the old hospitals. What was *not* exported was a sufficient proportion of the money that had been spent for decades on the asylum approach to care. The World Health Organization[9] reports that CC expansion did not kept pace with asylum closures in many countries, leaving a 'service vacuum' wherein significant numbers of patients receive inadequate support. In the UK, for example, a review by the Care Quality Commission[10] identified numerous critical failings, including breaching of patient rights, and substandard inpatient, crisis, and out-of-hours care. Furthermore, while CC was originally presented as synonymous with an increase in patients' civil rights, numerous countries have introduced increased legislation for granting powers of coercive medical treatment outside the hospital. For example, supervised compulsory treatment orders (CTOs) are commonly used to enforce medication adherence in one's own home, despite their ethical implications and inconsistent evidence of benefit (e.g., impact on medication compliance, number and duration of hospital admissions, and quality of life[11]). Although these compulsory powers were partly prompted in response to a small number of high-profile assaults perpetrated by psychiatric patients, concerns have been expressed that authoritarian, coercive treatment models (whether

administered chemically via medication or physically via enforced hospital committal), may actually increase risk through reducing patients' incentive to engage with services.[12]

The perceived failings and inadequacies of CC have provoked significant levels of debate in the past 50 years.[13] On one hand, this dialogue can be framed in practical and procedural terms: e.g., how services are commissioned, organized, and delivered. However, the focus of this article is on an alternative aspect: the ideological basis on which CC operates and, crucially, what changes we believe are necessary to drive the shift towards more humane and effective mental health services.

The Need for a Paradigm Shift

It is our contention that the biomedical underpinnings on which CC is based has resulted in a general exporting of the asylum mindset – the confinement and control of supposed biological diseases – into community settings. We would further suggest that a major difficulty with contemporary models of CC is that they are premised within what has been deemed 'a technological paradigm'[14] or what the psychologist Lucy Johnstone[15] characterizes as "patients with illnesses" as opposed to "people with problems." Here we reiterate the work of Bracken et al.,[14,p.430] who outline the assumptions of this paradigm as it applies to psychiatry in the following terms:

1. Mental health problems arise from faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual.
2. These mechanisms or processes can be modelled in causal terms. They are not context dependent.

3. Technological interventions are instrumental and can be designed and studied independently of relationships and values.

While critics of this framework do not deny that some patients find it beneficial, a major assertion is that other ways exist of conceptualizing distress (specifically, as a response to life events rather than a biogenetic disease); that these are scientifically and morally justified; and that for many can be a turning point in the recovery journey. In the following sections, we outline some of the major limitations with the technological paradigm's hypotheses (for further discussion, see also [16-18]).

Abnormal Processes within the Individual

In general medicine the technological paradigm is applied to treat physical processes, wherein precise empirical evidence usually - although not always - provides doctors with logical grounds for a chosen intervention (e.g., as in the case of cancer, cardiac disease, or AIDS). However, this is not equally applicable for functional psychiatric diagnoses, for which no categorical, aetiological models have ever been documented. As observed in a paper published in the *British Journal of Psychiatry*, authored by 29 practicing psychiatrists: "We suggest that this paradigm has not served psychiatry well. Ignoring fundamental epistemological issues at the heart of our models does not make them go away. Moreover, it does not yield results that are consistent with the demands of evidence-based medicine."[14 p.430-431]

For example, in contrast to continuing innovations in other medical disciplines, no mechanistically novel psychiatric drug has been marketed in over three decades; a situation largely explicable through a continuing lack of knowledge about the pathophysiology of

mental health problems.[19] It is further notable that the major classes of psychotropic agents (antipsychotics, antidepressants, anxiolytics) were discovered on the basis of chance clinical observation rather than targeted development (e.g., preclinical or genetic data, disease pathophysiology drawn from animal models), and thus do not meet the criteria for modern drug discovery methods.[19] In turn, the most popular and prevailing locus for mental health problems, that of the 'chemical imbalance,' is largely attributable to the modes of action of these drugs (e.g., the discovery that antipsychotic compounds block D_2 receptors is the basis of the 'dopamine theory of schizophrenia' which claims hallucinations and delusions are caused by hyperactive signal transduction in the dopaminergic system). However, as noted by Jackson,[20] this is essentially a model in which a condition has been hypothesized to account for a drug mechanism, rather than designing a drug to treat a specific disorder. As Kendall, writing in *The British Journal of Psychiatry,* describes it: "the story of the atypicals and the SGAs [second-generation antipsychotics] is not the story of clinical discovery and progress; it is the story of fabricated classes, money and marketing." [21,p.266-267]

In an absence of identifiable biomarkers, psychiatry relies on a system of symptom-based diagnosis and treatment that Thomas Insel,[4] the director of the National Institute of Mental Health (NIMH), has likened to "creating diagnostic systems based on the nature of chest pain or the quality of fever", additionally noting that symptom-based diagnoses are increasingly rare in other medical disciplines because they rarely designate the most suitable intervention. The pervasive problems with the reliability of psychiatric classification is well-documented,[22] and is probably best typified in clinical practice by the familiar sight of patients with numerous conflicting diagnostic labels. Indeed, in response to the publication of the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), NIMH issued a statement of intent to re-orientate its research away from DSM classifications in favour of assembling genetic, imaging, physiologic, and cognitive data (whilst also

acknowledging that sufficient information does not currently exist to develop such a system).[4]

Taken together the technological paradigm reflects a tendency towards medicalizing and pathologizing human experience,[14] despite an absence of adequate empirical data to justify this approach. This is a type of reductionism famously and powerfully critiqued since the 1960s in the work of the 'anti-psychiatrists' Laing and Szasz, although more recent critiques were apparent following the publication of DSM-5, including an international statement of concern[23] as well as grave reservations from the Chair of the DSM-IV taskforce.[24] In a related point, Bracken et al.[14] also note how the assumptions of the technological paradigm have made psychiatry vulnerable to corruption through its close alliances with the pharmaceutical industry, which in turn risks undermining trust and integrity in the profession.

This is not to deny that some individuals with mental health difficulties evince a series of detectable neurophysiological changes. Nor is it to suggest that neuroscience has no role in advancing understanding of the causes of, and effective treatments for, mental health problems. However, as will be discussed below, a key issue is considering these changes within their appropriate context.

Abnormal Processes are Independent of Context

According to the technological paradigm, mental illness can be modelled in universal causal terms independently of individual circumstances.[14] This can be seen in the emphasis of faulty biological mechanisms discussed above, as well as the discipline of 'descriptive psychopathology,' a phenomenological tradition that accentuates the form of psychiatric symptoms rather than their subjective content. In fact, evidence in the last decade has

demonstrated beyond reasonable doubt that mental health problems are associated with a broad range of adverse contexts, particularly (but by no means exclusively) childhood adversities. For example, the WHO World Mental Health Survey (n=51,945) reported strong associations between childhood maltreatment and first onset of 20 DSM-IV disorders,[25] with childhood abuse additionally increasing the likelihood of greater clinical severity (e.g., self-harm and suicidality, hospitalisation frequency and duration, medication dosage, global symptom burden[26]). It is important to emphasise that such associations also extend to psychotic experience, despite its long-standing status as a primarily biogenetic condition, and which are not only dose-dependent but remain significant when controlling for a broad range of confounding clinical and demographic variables (for review see[27-29]). In turn, psychotic symptoms have been found in some cases to be thematically congruent with previous experiences of adversity,[30-32] such as hearing the voice of a perpetrator. Indeed, seeking intelligible links between adverse life events and the content of psychotic symptoms is a therapeutic aspect emphasised during psychological formulation, on the grounds that "[s]uch links often provide indications of long-standing unresolved difficulties and associated negative self-evaluations…which may be closely intertwined with processes maintaining delusional beliefs and voices and may underpin aspects of the emotional reaction" [33,p.127] (see also [34-35]).

Give the substantial evidence for the impact of adversity on the brain,[36-38] the technological paradigm's essentialist framework - that neurological and biochemical abnormalities observed in adult patients have a causal etiological status independent of psychosocial circumstances – must clearly be called into question. An example of a contrary approach is the Traumagenic Neurodevelopmental (TN) model of psychosis,[39-40] which outlines the reciprocal interactions between environmental stressors and cognitive, affective and biological elements in the individual. By demonstrating the profound similarities between

functional/structural abnormalities in the brains of abused children and those of adult psychosis patients (which in turn correspond to differences between psychotic patients and healthy adults, and traumatized and non-traumatized children) the TN demonstrates that adverse events cannot reasonably be minimized to 'triggers' for a genetic predisposition, but should be considered as causal events in and of themselves. In terms of the technological paradigm it is interestingly placed, because while it conforms to assumptions that mental health problems arise from disordered processes that can be modelled in causal terms, it also locates these processes in the psychosocial context in which they arise. This is a crucial difference, for while the TN model is empirically supported,[40] it is also able to highlight how positivistic approaches have the capacity to decontextualize misery and mental distress.

Instrumental Interventions

Technological approaches to psychiatric care prioritize instrumental interventions that supposedly address explicit disorders, with factors like narrative, subjective meaning, and interpersonal relationships often minimized,[14] or even dismissed entirely.[41] This is evident in the case of pharmacotherapy, but also in some forms of cognitive therapy, and is a framework that Radden[42] likens to 'a repair manual' of mental health. In turn, Thomas and Longden[17] argue that such models have prioritized empiricism in a way that stifles the caring impulse; and as such are fundamentally incapable of engaging with human suffering in a principled way.

Whilst not denying that some patients find pharmacotherapy helpful, it is important to acknowledge the lack of evidence for the capacity of psychiatric drugs to successfully target and remedy a hypothetical 'chemical imbalance,'[43] as well as findings that pharmacology has only a partial influence on ameliorating complex mental health difficulties. [5,44-46]

Furthermore, many benefits associated with mental health treatments are robustly attributable to non-technical aspects.[14] For example the placebo effect – a complex phenomenon linked to non-specific factors like hope, positive expectancy, and personal meaning – is known to have an impact in trials of antidepressants,[47-48] antipsychotics[49] and ECT.[50] Likewise the nature of the therapeutic alliance can often be a better predictor of outcome than the specific, technical properties of a given therapy – a phenomenon known as 'the equivalence paradox.' For example, a comparison of 5,613 cases involving cognitive behavioural therapy (CBT), person-centred, or psychodynamic therapy over three years found that the therapeutic alliance accounted for the largest proportion of variance in clinical outcomes, with no specific technique emerging as superior.[51]

Other non-specific factors suggested to influence psychotherapy outcomes include individual client factors, such as resilience, self-esteem and coping skills,[52] and extra-therapeutic events,[53] although it is the therapeutic relationship that tends to show the strongest associations. For example, a recent RCT of 308 patients treated for acute psychosis has demonstrated that the quality of the therapeutic alliance in both CBT and supportive counselling has a causal effect on symptom outcome, with poor relationships being actively detrimental.[54] Factors deemed particularly important include cooperation, collaboration, empathy, and responsiveness,[55] although these are not limited to psychotherapy; a good relationship with one's prescriber is likewise associated with better outcomes in drug treatment.[56-58] However, the benefit of compassionate interactions that nurture a sense of confidence, connection and autonomy is by no means a new discovery; its value was recognized as early as the 18th century in the concept of 'moral therapy,' a humane (albeit paternalistic) alternative for the care of asylum inmates. Historians generally agree that the promotion of 'kindness, dignity, and decency' enjoyed striking success in a pre-pharmaceutical and pre-therapy age. For example, from 1833-1853 the Worcester State

Hospital in the United States discharged 71% of first-episode patients as 'cured,' with rates of 59% for those with longer pre-admission disturbance, and only a minority identified as chronically ill.[59]

Moving Forwards: Models of Psychosocial Care

Taken together, a growing body of evidence refutes the idea that a 'technical idiom'[14] is a suitable way to approach CC delivery. Indeed, as discussed, there is reason to believe that the primacy of technological paradigms may actually hinder recovery for some service-users. Dillon[60] summarizes this paradox in the following way: that one's 1) emotional crisis (a supposed biogenetic abnormality) is responded to with 2) denial (the emotional meaning of experiences like voice hearing or unusual beliefs are ignored and the role of painful life events disregarded), which is followed by 3) insight (the patient accepts their biological illness), followed by 4) 'recovery' (symptoms are controlled by medication), and which finally results in 5) relapse (the initial crisis continues to reoccur, for in addition to the person's underlying, unresolved emotional problems, they may also face stigma, exclusion, medication side-effects, and a sense of hopelessness). Thus a cycle of maintenance and chronicity may become established.

Nevertheless, despite limited scientific evidence to justify it, substantial accounts of the harm it can cause, and extensive evidence for the role of psychosocial factors in mental distress, technological approaches to psychiatric care continue to endure. There are numerous influences that contribute to sustaining this dominance. While a full account is beyond the scope of the current article, they include (but are not limited) to the following factors, summarized thus by Rapley et al.: "The medicalization of suffering and difference thrives because it sanitizes and simplifies."[61,p.4]

1. **Political interest.** It is politically convenient for policy makers to emphasize individual biology in ways that decontextualize mental health problems and thus deflect scrutiny from damaging social systems. Childhood abuse and neglect, adulthood assault, poverty, and discrimination have devastating personal consequences, yet medicalizing subsequent distress permits a level of denial and distancing that absolves those in power of responsibility for addressing injustice and instituting legislative change.
2. **Economic interest.** The influence of the pharmaceutical industry on psychiatric practice, training, and clinical research has attracted sustained concern and criticism.[62] Nevertheless, financial motives for perpetuating biological models of mental distress are considerable, and may be one of the most powerful barriers to change. For example, in the United States alone sales of psychiatric medications generated $25 billion in 2011[63] (for comparison, the net income for the Google corporation in 2012 was $10.74 billion).
3. **Professional interest.** Constructing a clinical problem (whether in terms of disrupted biological systems or dysfunctional psychological mechanisms) promotes the need for specialist, scientific expertise. As such, many aspects of the 'Psych' professions are premised on emphasizing problems within the individual as the main target for intervention, wherein contextualizing mental health problems and acknowledging damaging social/political realities presents profound challenges to the legitimacy of its "self-defined subject matter." [64,p.37]
4. **Interpersonal interest.** Some families may have a vested interest in conceptualizing their relatives' difficulties as an illness rather than the result of damaging life events. However, with the exception of caregivers who deliberately inflict cruelty or neglect, locating the origins of distress within the family of origin should not be seen as a

blaming impulse. Conversely, recognizing the impact of poverty, attachment disturbances, social conflict, and intergenerational trauma can help to acknowledge and address the needs of both patients and their families in more restorative ways.[65]

5. **Individual interest.** The process of societal/political denial and distancing also operates on an individual level. Emphasizing a categorically different group characterized by fundamental biological/genetic abnormalities drives the reciprocal mechanisms of fear, avoidance, and scapegoating which, in turn, exaggerates the differences between 'the mad' and 'the sane' and denies the dimensionality of emotional distress. On one hand, this protects our need to see ourselves as different from 'the mentally ill', but is also a way to avoid contemplating the need to address violence and injustice within one's society. In turn, patients may also internalize medical paradigms, either to protect themselves or their families from painful realities, or to devolve responsibility for 'cure' to mental health services in an unconscious attempt to meet a need for caring input that may have previously been withheld (e.g., during childhood).

Taken together, there are clearly considerable influences that contribute to maintaining a status quo, both in CC and approaches to mental health more generally. Is there any cause for optimism about the feasibility of a paradigm shift?

Although the progression towards more psychosocially responsible services is protracted and slow, there are still grounds to note important developments in recent years. Firstly, this includes a notable growth in academic interest for psychosocial approaches to complex mental health difficulties (e.g., the number of research articles considering links between schizophrenia and trauma has more than doubled in the past ten years compared to

the previous decade[i]). Whilst the lengthy interval between research findings and practical implementation is well recognized in applied disciplines, there is nevertheless growing indication that these ideas are beginning to be partially fulfilled at a service level. In the UK, for example, National Health Service guidelines advocate asking all psychiatric service-users about trauma exposure;[66] and the British Psychological Society's Division of Clinical Psychology has emphasized the utility of psychotherapeutic approaches to so-called pathognomonic symptoms of schizophrenia, like voice hearing and delusions.[35] Whilst such frameworks do not yet constitute standard practice, Boyle[64,p.30] makes the important observation that "the evidence causally linking social context to distress…is plentiful and robust, so that there is a limit to how far clinical psychology and psychiatry can avoid it without raising questions about their status as evidence based disciplines."

There are also many signs of growing unity and fellowship between groups of individuals wishing to promote non-technical paradigms to mental distress. This includes influential survivor-led organizations, such as the Hearing Voices Movement (intervoiceonline.org), Mind Freedom International (mindfreedom.org), and Mad in America (madinamerica.com), in which coalitions of survivors and their allies critique reductionist approaches to mental wellbeing, and raise awareness of the perceived abuses and violations associated with them. Professional bodies like the Critical Psychiatry Network (criticalpsychiatry.net) and the International Society for Psychological and Social Approaches to Psychosis (isps.org) likewise advocate for progressive reform within the mental health system. In turn, research shows that members of the public across the world (with the general exception of the United States) show a consistent preference for psychosocial explanations and treatments for mental distress over technical, biomedical ones.[67]

[i] Based on a Scopus search (schizophrenia AND trauma OR abuse): 5,304 articles published between 2004 and 2014; 2,166 published between 1993 and 2003

Testimony from those with lived experience of mental health problems has also successfully highlighted the inadequacy of technological models for understanding the nuances of distress and recovery. For example, contrary to a clinical focus on symptom cessation, the concept of 'personal recovery' emphasizes factors like connectedness, hope, identity, meaning in life, and empowerment[68] – factors which can, and do, occur outside of the mental health system. In turn, survivor-led recovery literature challenges assumptions that the impact of mental health crises are inevitably and exclusively negative which, whilst not negating the fear and pain many patients experience, emphasise how experiences of mental distress, including psychosis, "have ultimately informed and augmented…wellbeing (e.g. through a heightened capacity for political engagement, creativity, compassion, fortitude, and self-knowledge)."[69, p.25] There is also the knowledge that clinical, technologically-led treatments are only one of several possible routes to recovery,[68] as well as the recognized fact that people with diagnosable mental health problems may often live successfully outside of psychiatry (e.g., they are not distressed by their experiences/actively value them; or they have a non-medical or non-psychological framework, such as spiritual or cultural beliefs). Taken together, these are diversities and complexities that purely technological paradigms are unable to successfully accommodate.

As Bracken et al.[14,p.432-433] express it, "The evidence base is telling us that we need a radical shift in our understanding of what is at the heart (and perhaps soul) of mental health practice...good psychiatry involves active engagement with the complex nature of mental health problems, a healthy scepticism for biological reductionism, tolerance for the tangled nature of relationships and meanings and the ability to negotiate these issues in a way that empowers service users and their carers." In this respect there are several examples of holistic, sociocentric services that demonstrate the feasibility of working outside a technological paradigm. These include the Sanctuary Model,[70] the Soteria paradigm,[71] and

Open Dialogue family and network approach,[72] all of which are configured at organisational and clinical levels to promote psychological growth and reconstitution, and which broadly emphasize communal, social, and dialogical processes with minimal medication use. Furthermore, while options for patients and professionals enmeshed in more conventional services can appear limited, there are still avenues for facilitating and promoting positive change. Examples of potential strategies are presented in Table 1.

- Table 1 here -

Conclusions

This article began with an account of the beleaguered status of modern psychiatry and, by extension, the models of CC over which it presides. In turn, we have outlined some of the major theoretical and practical weaknesses of its associated technological paradigm, as well as indications of – and practical suggestions for – the institution of paradigm change. Taken together, this type of discontent supports the contention that a conceptual shift in mental health is not only necessary, but also feasible, and inevitable. In doing so, we do not suggest that empiricism has no place in mental healthcare, or that biomedical theory and practice have no benefit. However, as we have outlined, there is also evidence that a radical reappraisal is needed of how these factors are currently applied within CC.

In a paper considering the historical links between schizophrenia, trauma, and dissociation, the psychologist Andrew Moskowitz[73, p.351] applies the reasoning of the philosopher Thomas Kuhn to this very question. According to this perspective, intellectual and practical changes occur when incongruities and contradictions undermine the basic hypotheses upon which the ‘old rules’ of a particular discipline were established. The

ultimate outcome is conceptual revolution, and a shift from 'ordinary to extraordinary' in research, theory, and practice:

> Kuhn (1970) argued that paradigms change and a *scientific revolution* ensues when three conditions are met: (a) a period of crisis develops in which the paradigm fails to adequately answer questions considered fundamental; serious 'anomalies' occur in which phenomena not clearly compatible with the paradigm are observed; and, importantly, (c) a suitable alternative paradigm that explains many of the previous findings and at least some of the observed anomalies comes to light. Kuhn saw scientific revolutions as taking time to resolve; he argued that changing such strongly held beliefs involved a process of persuasion and fundamental reorganization not unlike that of religious conversion: 'Conversions will occur a few at a time until, after the last holdouts have died, the whole profession will again be practicing under a single, now different paradigm (Kuhn, 1970, p.152).

In a recent paper asking the question 'How much evidence is required for a paradigm shift in mental health?'[41, p.477] two authors of the current paper also invoked Kuhn's work:

> As Kuhn pointed out, an accumulation of evidence contradicting a long-standing paradigm is not sufficient, because the 'last holdouts' have a myriad of strategies to minimize, distort and deny the new evidence. He referred to the need for less 'scientific' processes such as enthusiasm and persuasion. Perhaps the most exciting, and persuasive, recent development has been the rapid development of the Hearing Voices movement (www.intervoiceonline.org). Many voice hearers all over the world, tired of waiting for the paradigm shift that the research evidence demands, are supporting one another and training mental health professionals how to help when asked.

The closing of the old hospital asylums, and the accompanying move to CC, had the potential to facilitate genuine change. Yet the hospitals, although smaller, still remain the lynchpin of services. And beyond the hospital, the medical model and its decontextualized technologies still dominate, along with the constant threat of compulsory treatment. Growing doubt and dissatisfaction around these technological approaches to mental health are, however, fuelling the search for more suitable models with which to theorise and respond to human distress. The challenge for the next generation of practitioners is to extend beyond

reductionist biological models and acknowledge the complex influence of psychosocial, political, relational, and cultural components in which mental health problems are inevitably embedded, and then to develop treatments and supports that address those real causes of human distress. It is both as straightforward – and as complex – as that.

Author Contributions

Eleanor Longden: drafting and critical revision; final approval.

John Read: article conception; drafting and critical revision; final approval.

Jacqui Dillon: drafting and critical revision; final approval.

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Table 1. Practical strategies for facilitating a paradigm shift in mental health care.

Individual level	Inquiring about service users' lives and how they think adversity exposure may have impacted on their current difficulties. Asking service-users what they need and what type of support they feel would be most helpful. Encouraging colleagues to focus on recovery rather than pathology. Forming alliances with progressive professional organizations, and groups of families and service users. Avoiding language that is stigmatizing (e.g., 'schizophrenic') or pathologizing (e.g., 'illness'). Lobbying for change to local and national government, mental health service managers, and in social and corporate media.
Service/provider level	Active involvement of service users in the design, management and evaluation of services. Facilitating service user-led training and research. Refusing to accept money from the pharmaceutical industry. Supporting psychiatrists to share the responsibility for risk management. Initiating or supporting relevant psychosocially-focused training.
Societal level	Advocating for reduced coercion and involuntary treatment in services and legislation.

	Advocating for primary prevention (e.g., child protection; domestic violence services; anti-bullying policies). Publically emphasizing the psychological consequences of victimization, inequality, discrimination and other forms of injustice. Drawing attention to attempts by the pharmaceutical industry to influence mental health policy, research, and service provision.

Note. Adapted from "Creating evidence-based, effective and human mental health services: overcoming barriers to a paradigm shift," by J. Read and J. Dillon, 2013, in *Models of madness: psychological, social, and biological approaches to psychosis* (eds. J Read, J Dillon): 392-407. London: Routledge.