

Wesley E. Sowers · Hunter L. McQuiston ·
Jules M. Ranz · Jacqueline Maus Feldman ·
Patrick S. Runnels *Editors*

Textbook of Community Psychiatry

American Association for Community Psychiatry

Second Edition

 Springer

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Much has changed since the publication of the Handbook of Community Psychiatry in 2012. We are indebted to the many contributors to this edition which has morphed into a textbook. There are many new chapters and new authors who have joined in this attempt to produce a comprehensive accounting of the work and ideas of the multitude of psychiatrists working in the field and dedicated to serve the community at large. There has been growing recognition of the primacy of the community service perspective in meeting the needs of our population and increasing interest among young psychiatrists entering the profession.

This work stands on the shoulders of many of the giants of community psychiatry who have passed before us. There are too many for us to mention them all here. We are especially saddened by the loss of three of these paragons of our profession who contributed to the first edition of this book. Carl Bell, Joel Feiner, and Richard Warner were tireless in their efforts to promote social justice and to serve distressed communities. They were advocates, mentors, and superb clinicians, and they will long serve as examples for all of us who continue to have the pleasure of doing this work. We hope that the pages of this book will serve as a memorial to their lives and work.

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Jules M. Ranz MD, is Clinical Professor of Psychiatry at Columbia. He was director of the Public Psychiatry Fellowship at NYS Psychiatric Institute/Columbia University Medical Center from 1992 to 2017 and continues as a member of its faculty and mentor to many of the over 300 psychiatrists who completed the fellowship. The Public Psychiatry Fellowship is generally acknowledged to be the premier program of its kind in the country. In the past decade, 20 other public/community psychiatry fellowships have been created, most modeled on the Columbia program. During this time, Dr. Ranz has created a network of directors of these programs and has encouraged six of the fellowships to publish articles describing their individual programs. Dr. Ranz was principal author of a 2006-published article written by the Mental Health Services Committee of the Group for the Advancement of Psychiatry, utilizing data to demonstrate that early and mid-career psychiatrists spend more time in publicly funded organizational settings than in solo office practice. A follow-up paper described a 12 site study conducted by Dr. Ranz and that same committee: “A Four Factor Model of Systems-Based Practices in Psychiatry” published in 2012. In recognition of his long career as a public psychiatry educator, Dr. Ranz received the 2013 APA/NIMH Vestermark Psychiatry Educator Award. Following his semiretirement from the Columbia Fellowship, Dr. Ranz helped to create a Community Psychiatry Nurse Practitioner fellowship at a Federally Qualified Health Center, which was described in a 2021 publication in *Psychiatric Services*. He is continuing to serve as an advocate for bringing psychiatric nurse practitioners and psychiatrists together to collaborate on both academic and advocacy levels.

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Patrick S. Runnels MD, MBA, serves as both chief medical officer of population health and vice chair of psychiatry for University Hospitals in Cleveland. Additionally, he holds an academic appointment as professor at the Case Western Reserve University School of Medicine, where he founded the Public and Community Psychiatry Fellowship. Additionally, he was the founding chair and remains an active member the National Council on Mental Wellness Medical Director Institute. He has served in the past on the board of trustees of the American Psychiatric Association, the National Alliance on Mental Illness (Ohio Chapter), and the American Association for Community Psychiatry. He has also served as chair of the Council on Advocacy and Government Relations for the American Psychiatric Association. Dr. Runnels received his medical degree from the University of Missouri, Columbia, had his psychiatric residency at the Mount Sinai Hospital in New York City, and then completed the Columbia University's Fellowship in Public Psychiatry. He received his executive MBA from Case Western Reserve University Weatherhead School of Management. He has published several articles, editorials, and book chapters, as well as given numerous national talks and presentations in the areas of healthcare leadership and clinical transformation.

Part I

Introduction and Background



Introduction: Community Psychiatry on the Move

Hunter L. McQuiston, Wesley E. Sowers,
Jules M. Ranz, Jacqueline Maus Feldman,
and Patrick S. Runnels

This Textbook is a key expansion of 2012's *American Association of Community Psychiatrists Handbook of Community Psychiatry* (McQuiston et al. 2012). With this edition, we aim to deliver a comprehensive examination of the many phases of public and community psychiatry, offering a foundational resource for anyone working for community well-being in behavioral health. While the volume primarily focuses on psychiatry's role in community behavioral health, the bulk of chapters are relevant to training and ongoing education for a range of allied professionals and policymakers. At the core of this textbook is

a commitment to document and expand the range of professional knowledge, skills, and awareness of those who themselves dedicate their work to communities of people.

Concerning the role of psychiatry, community psychiatry itself as a field or subspecialty is so broad that it handily encompasses domains of public policy, teaching and research, program management and administration, and, of course, clinical work. Self-identified community psychiatrists flexibly work in multiple roles over their careers and not infrequently covering multiple domains simultaneously. This bestows the benefit of breadth of view in their work and enables them to address patient care from all 360 degrees of biopsychosocial and to some, arguably, spiritual conceptualization.

An important, and unique, dimension affecting the need to diligently update the field is how community psychiatry is affected by social, cultural, and political changes. For example, the past 10 years have brought deep turmoil to America, with a widened political division that challenges consensus on how to solve both old and new social problems. As of this writing, in mid-2022, cardinal issues include an overdue re-examination of the cultural status quo, most particularly defined by the crucible of human rights: the struggles of Black and other people of color. This is compounded by an international humanitarian crisis of refugee migration owing to war and social violence, including American immigration

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and asylum-seeking. Continuing are wholly inadequate efforts to improve the lives of people with mental illnesses who are homeless or incarcerated. A demoralizing viral pandemic has raged across all social strata, too, compounding traumatic loss, both personally and economically, with effects on well-being that are yet evolving. In our view, the COVID-19 pandemic has exacerbated a political crisis that separates communities, sometimes even with hateful speech and action. Additionally, the specter of war has threatened international stability as not other conflict since World War II. And finally, there is accelerating urgency to address climate change, itself an ultimate social determinant of mental health, and indeed the most serious existential threat facing humanity.

The picture may feel dystopian, but we would be mistaken to discount efforts to adapt and even thrive by using both time-honored and developing ways to promote community wellness. The above-noted issues, and others, affect how today's community psychiatry focuses its energy. These efforts are duly addressed throughout the chapters of this book's Edition. Resonant with this is this *Textbook's* thread of focusing attention on the domain of primordial prevention (Association of the Faculties of Medicine of Canada 2022), otherwise described as addressing social determinants of health. Over the past 10 years, the concept of social determinants of health has, at last, advanced to the level of accepted terminology, giving community psychiatry's expertise even greater recognition through its role in exploring them in research together with the social sciences.

Similarly, community psychiatrists are often sought in their daily work to ameliorate or eliminate the human cost of these problems, through roles in direct service, clinical administration, governmental policy, and organized psychiatry and even in overseeing quality in managed care. Because these psychiatrists understand that the parts of behavioral healthcare *are* always moving, they hold systems-savviness and are therefore sought out as experts for practice adaptation and change.

This overlaps a crucial aspect of community psychiatry also weaved into this book: advocacy. This book is a vehicle for the American Association of Community Psychiatry (AACP) and in this way reflects advocacy as a foundational value. As testament and illustration of this, AACP recently modified its name from "...of Community Psychiatrists" to "...for Community Psychiatry," accentuating the value of advocating for population health and the integrity of communities. This name change also reflects the need for a broader vision of community psychiatry in which a multidisciplinary collaboration prevails.

While the *Textbook's* attention to societal events strongly reflects the spirit and substance of community-oriented service delivery and its research, technical and phenomenological developments have also affected practice, some in direct relation to these events. The rapid growth of virtual and other electronic technologies is a prime example, expanding exponentially during the pandemic. Similarly, over the past decade, the electronic health record (EHR) has become commonplace, enabling enhanced clinical communication, including directly with patients. Paradoxically, the burdens of EHR documentation can also be tagged as contributors to physician burnout, yet another development causing many psychiatrists to experience a sense of less time spent with their patients, compounding the continuing pressure for service volume driven by reimbursement in organized practice settings. Indeed, the last decade has evolved a growing concern about a diminishing and aging psychiatric workforce in the public sector, even as demand increases. It is hoped that this will be offset by the prospect that recruitment of medical students to psychiatry is on the rise (Psychiatric News, April 21 2021), that psychiatric residency programs are increasingly sensitive to the effect of social determinants of mental health, and that community/public psychiatry fellowships have increased in number, from 2 in 2007 to 26 in 2022.

So, despite serious challenges to practice, community psychiatry has firmly established itself within today's profession, and there is reason for optimism in its role on the future pan-

orama of behavioral healthcare. This highlights another of this *Textbook's* functions: it is a guide for trainees and early career professionals as they begin to shape the contours of community psychiatry's influence on both macro- and micro-level changes in healthcare.

In this manner, this *Textbook* also helps fulfill this aspect of AACP's mission:

...to promote health, recovery and resilience in people, families and communities by inspiring and supporting community psychiatric care providers, and in transforming behavioral health care;

while it pursues this element of its Vision Statement:

[to] develop and disseminate knowledge and skills for effective and sustainable practices and systems to advance population health.

With the *Textbook* as a tool not only for the present practice environment, the rising generation of practitioners and leaders in community psychiatry will have a solid and uniform basis of knowledge and reference for their efforts to advance their clinical work and advocacy, continuing to build the subspecialty as times change.

Therefore, this edition offers an exposition and elaboration of the AACP's goals by examining the historical, philosophical, and scientific basis and development of community and public service psychiatry. The *Textbook* helps the AACP's efforts to effect technology transfer and professional development, and it does so by supporting the AACP Certification in Community and Public Psychiatry. It is an updated study guide for the Certification examination, with many examination questions arising from its chapters.

In terms of content, we have keenly focused on a consistency of approach to patient care, in systems management, public policy, training and education, and research priorities among the chapters. We have drawn on expert chapter authors, especially AACP members, who share the organization's goals. We are deeply indebted to them for their energy, vision, and hard work in preparing their ideas for our readers. We are par-

ticularly honored by those authors who are not psychiatrists – colleagues in psychology, social work, nursing, and the peer community – who have been crucial in assuring comprehensiveness and perspective within the volume while also reflecting the inherently multidisciplinary and collaborative nature of community psychiatry. Finally, we are indebted and pay homage to those contributors to the 2012 Handbook who are now deceased and missed, leaders and mentors in our field who are noted throughout the book.

How the Book Is Organized

The *Textbook* is organized into nine sections, or parts, that cover topics that are relevant to the conceptualization and practice of clinical work, but also give a theoretical basis, as well as historical context, to the various topics within community psychiatry.:

Part I: Introduction and Background

After this Introduction, chapter “[History of Community Psychiatry](#)” sets the stage by describing the historical evolution of community psychiatry, offering chronological development of where behavioral health services are today. The emphasis is on the US behavioral healthcare system, but that system could not have itself evolved without traditions and initiatives going back centuries, primarily in the Western world.

Part II: The Basics: Central Pillars of Community Psychiatry

Part II covers essential features of practicing in community-oriented systems, and it represents our view of what are cardinal values in today's behavioral healthcare: recovery and person-centeredness, population health and prevention, leadership and collaboration, advocacy and social justice, and care integration and comprehensive services.

Part III: Core Competencies for Community Psychiatrists

Once basic principles have been understood, essentials of successful clinical practice can be gathered. These include creating a service culture that is welcoming to people seeking help, developing enlightened service planning that is also trauma-informed, and how to employ techniques and clinical skills to address challenges commonly experienced by those we serve.

Part IV: Effective and Established Interventions

Expanding on technique, Part IV examines clinical and rehabilitative practices that have been shown to be particularly effective in helping people pursue personal recovery goals. These span a discussion of evidence-based practices (EBPs) and their tension with the “practice-based evidence” that grows out of clinical experience, wisdom, and quasi-experimental data. How EBPs inform interventions for co-occurring mental illnesses and substance misuse is examined in this light. Included in practical approaches, the section also covers the ascendance of cognitive behavioral therapy, both for general psychiatric populations and its important emergence for psychosis (discussed in Part VII). Also covered here is the critical tool of psychiatric rehabilitation, not infrequently glossed over in psychiatric training, with specific references to other chapters in this book that, together, thoroughly discuss all its aspects. The section also includes the role of emergency services as well as reviewing the current state of assertive community treatment. Often not emphasized, but so important to community well-being, is a chapter on families and the interventions tailored to them.

Part V: Creating Healthy Communities

In the end, supporting community health is a central mission of public service. Its application to community psychiatry is given detail in Part

V. The stage is set by the basic science of community psychiatry, epidemiology. It then moves from the quantitative to the equally significant qualitative effects of community, political, and social effects on community well-being. Operationalizing community psychiatric principles is explored in the chapter on community collaboration, as well as with one presenting services research precepts and methodology. Part V also examines the specific community disruptions caused by incarceration, disasters, and the impending global effect of an 800-pound gorilla: climate change.

Part VI: Supportive Services for Community Living

In coping with societal realities, Part VI addresses responses by advocates, policymakers, and behavioral health program planners to address social determinants of mental health challenges, with the goal of blunting their effect. This section therefore delves into issues that affect housing and employment and the challenges of service coordination. Because the recovery experience cannot progress in isolation, particularly with the vicissitudes of societal impediments, this section discusses social supports through the clubhouse movement, with peers, as well as how a person can mobilize personal wellness.

Part VII: Special Populations

So much of community psychiatry is defined by conceptualizing and working with clinical populations. From a clinical service vantage point, local communities manifest population needs, and any treatment of them in a volume like this one can never cover them all. However, Part VII focuses on how clinicians and organized systems of care can address the needs of ten prominent clinical populations based on demographics, rural residence, veteran status, sexual orientation, homelessness, and migration status. Also included in this section is detail regarding popu-

lations with a first episode or early psychotic challenge, along with practical description of cognitive behavioral therapy of psychosis.

Part VIII: The Development and Administration of Services

Extending the systems expertise inherent in public and community psychiatry into management is the business of Part VIII. Many public and community psychiatrists enter this arena in the interest of advocating for necessary change and the need to affect population health. The section covers an overall vision for a public mental health system, the role of medical director, the challenges of workforce development, the financing of behavioral health, how to successfully wrestle with clinical value, and, then, how to evaluate programming. It also explores the burgeoning universe of technology in behavioral health, an area that, as noted above, has expanded dramatically over the past decade.

Part IX: Shaping the Future

As we shape the future, three chapters are necessarily dedicated to the process of education and training, including how mentorship might even begin before medical school and how public and community psychiatry fellowships have a key role in mounting sophistication for work in pub-

licly funded clinical environments. Consequently, we pull together all the elements embraced by the textbook and deeply discuss future prospects in community psychiatry, including on an international level.

Finally, though this book does not attempt to minimize contributions of other recent treatments of community psychiatry (Rowe et al. 2011; Jacobs and Steiner 2016), it aims to reinforce and, in many respects, deepen the conversations emerging from them, offering an enlightening and comprehensive view. We hope the chapters in this book are rewarding for you, enabling the *Textbook* to meet its goals.

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History of Community Psychiatry

Jacqueline Maus Feldman

Introduction

Since antiquity, mental illnesses have proven challenging for individuals suffering with them, for families who wish to support them, and for communities in which they live. Evolution in the development of community services and supports has been predicated on the understanding or interpretation of mental illness, aided by acceptance and innovation, but often anchored in ignorance, stigma, and short-sightedness. Regardless of how one defines community psychiatry (by provider, by setting, by duration of care, by diagnosis, by set of principles, by finances/payer of services), multiple facets are important in the evolutions of the field. A historical review of community psychiatry is imperative to comprehend the variables that impact the lives of those touched by mental illness and may suggest how systems of care should be organized to enhance recovery.

As early as the Neolithic era, evidence exists that many attempts were made to treat and cure mental illness. Skeletal remains with large burr holes in their skulls from that era have been speculated to reflect interventions in brain disorders (Brothwell 1981). Records from ancient Egypt reported clinical presentations of depression and

somatization, with trials of magical spells, applications of body fluids, use of hallucinogens, and religious retreats to ameliorate these conditions (Nassar 1987). Hindu religious texts denoted interpretations of mental illness as reflections of supernatural beings imbued with magical powers, or as a result of the body being out of balance; the religious community responded with application of prayers, herbs, or persuasion (an early attempt at therapy?) (Bhuga 1992). Bodily imbalance was also embraced as an explanation for mental disorders by the ancient Chinese; treatment like herbs and acupuncture sought to bring these back in alignment (Yizhuang 2005). Ancient Jewish cultures viewed mental illness as a reflection of a discordant relationship with G-d. Eschewing theories that the etiologies of mental illness were supernatural or divine in nature, Hippocrates recommended close observation; accurately described numerous mental maladies; noted contributory roles of environment, diet, and lifestyle; and suggested treatment be focused on balancing bodily fluids. Ultimately Plato embraced the theory that all mental illness was predicated on physical problems, and a Greek physician became the first to suggest humane treatment, including releasing agitated patients from restraints (von Staden 1996).

During the Middle Ages, the Quran reflected the need to treat those who were mentally challenged with humane protectiveness; some Muslim physicians encouraged the development

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of trusting counseling relationships and developed patient-centered, supportive asylums from 700 to 1200 AD (Millon 2004). Unfortunately, such forbearance was not as readily apparent in Europe during the Middle Ages, where interpretation of mental illness again became tied to a “mixture of the divine, diabolical, magical and transcendental” (Millon, p. 38). Humors, spirits, and demons were all thought responsible for mental disorders, and the suffering individual was thought to be morally unfit and suffering from sin and punishment for a lapse in his relationship with G-d or possessed by the devil. During this time, the challenge of providing care for these individuals fell to families, although in England the courts often provided additional supports. Others were not so lucky and were the target of witch hunts; the “more” fortunate were removed (or pushed) from family care and shipped off to and restrained in almshouses, jails, or mad houses (Wright 1997).

The Age of Enlightenment marked a resurgence in the belief that mental illness was predicated on physical not moral problems, though patients were often seen as wild animals, needing restraint and physical punishment to ameliorate their animalistic furies. In America in the 1700s, the general medical Pennsylvania Hospital began to offer services for those with mental illness (though in its basement), and colonial Virginia opened the first mental health asylum in Williamsburg designated specifically for citizens with mental illness. Towards the end of the 1700s, the moral treatment movement occurred, with leadership provided by Phillippe Pinel in France and Tuke and the Quakers in England. Rees (1987) describes Pinel’s philosophy:

the insane came to be regarded as normal people who had lost their reason as a result of having been exposed to severe psychological and social stress. These stressors were called the moral causes of insanity and moral treatment relieves the patient by friendly association, discussion of his difficulties and the daily pursuit of purposeful activity; in other words, social therapy, individual therapy, and occupational therapy.” (pp. 306–307)

Before further exploring moral treatment in the United States and the evolution of psychiatric care that eventually culminated in expansion of

community psychiatry, a brief sojourn into the history of Geel is imperative, as it illustrates the potential and capacity for a community to embrace and support people with mental illness in a recovery-oriented fashion. Over 700 years ago, a city in Belgium, Geel, established a system of community care for those with mental illness that has been sustained, in some fashion, through this very day. By legend, it is told that in the sixteenth-century Dymphna, the daughter of an Irish king, fled to the forests of Geel to escape her recently widowed father, who in a grief-stricken delusion, demanded she marry him. Instead of acquiescing, she chose to be beheaded; named the patron saint of those with mental illness, the site of her martyrdom became a chapel that witnessed cures of mental illness. Pilgrims seeking miracle cures overwhelmed the region and the church onsite became their housing; at the bequest of the overwhelmed church, villagers from the surrounded area open their homes and thus began the tradition of “integrated, community residential care” (Goldstein and Godemont 2003). These often trans-generational foster families provided mental health care and support with virtually no formal training, and by the late 1930s over 3800 boarders were living with Geel families; for the most part “the role of the family as caretaker, teacher, natural supportive parent, and behavioral model allows the boarder to function in the normal social world” (p. 449).

By the 1950s, however, boarder populations began to decline. A study was initiated in Belgium in the mid-1960s to study Geel and its mental health-care system, as its original leader was expressing fears that the Colony would dwindle away. Instead, legislation has elevated the Colony to autonomous status, and new physician administrators have inspired evolution in the services rendered. More recent research reflects the majority of boarders are male, ages ranging from 15 to 75, half have intellectual disabilities, and over 20% are diagnosed with schizophrenia. Non-adherence rates are low, and a relatively low incidence of violence is reported. Each family has a psychiatric nurse assigned to them, and hospitalization is available if necessary. Of interest, boarders are not kept out of pubs (taverns),

which are “an important part of community social life” (p. 455). Historically largely agrarian (which offered boarders opportunity for farming jobs), Geel is now industrialized; boarders still are “given the opportunity to do meaningful work” (p. 456). Geel

acknowledges and accepts the human needs of the boarders and responds to those needs rather than acting on unfounded or exaggerated fears...because of their exposure to and experience with mental illness, the entire population protects rather than fears members of their community who are mentally ill. The living legend of Geel offers an opportunity to learn lessons that can encourage effective mental health care—community caring in caring communities.” (p. 456)

A more recent study of Geel (von Bilsen 2016) reflects the importance of “radical compassion and kindness” and “social integration, care in the community, and normalization” as instrumental for successful functioning in the community, as well as offering opportunities for destigmatization and acceptance of those living with mental illness.

Unfortunately, communities like Geel are difficult to replicate, but dedicated individuals continued to strive to enhance mental health care in America in the mid-1800s. Inspired by Phillippe Pinel, Dorthea Dix promulgated moral treatment reform in America. After failing to convince the federal government to embrace responsibility for those with mental illness (in 1854 President Franklin Pierce vetoed a bill that would have set up federally funded construction of mental hospitals), Dorthea Dix continued her campaign, begun in the 1840s, to convince state governments “to provide that which many of the ill patients lacked: stable housing, nutritious meals, supportive care in kind and calming environment...to provide asylum for those needing support and nurturing to cope with their mental illness” (Feldman 2010, p. 193). Asylums were constructed and patients admitted and “treated” (with kindness, housing, food, and work). While initially capable of providing succor and support, the institutions were quickly overwhelmed by an influx of society’s less fortunate (those with chronic medical illnesses like syphilis and dementia, orphans, and those who were impover-

ish); battling excessive caseloads and inadequate funding, humane treatment floundered in asylums, and patients were warehoused with little to no treatment or care offered (Crossley 2006). Although the introduction of ECT and insulin shock therapy ensued, many patients spent the remainder of their lives incarcerated in state hospitals. By the mid-1950s, the numbers of patients housed in American mental institutions peaked at over 550,000.

In the late 1800s and early 1900s, other reforms and treatments in mental health blossomed that set the stage for the evolution of institutional care ultimately transitioning to community-based care. The Mental Hygiene movement was led by Clifford Beers, a brilliant young financier who developed bipolar disorder, attempted suicide, and spent 3 terrible years in a state hospital in Connecticut. Against the recommendation of most of his friends and supporters, he felt compelled to document his course of care (even going so far as to get himself locked down on the freezing violent ward), hoping to improve care, to demonstrate to the general public that people with mental illness could recover, and to prevent mental illness and institutionalization. He was instrumental in the formation of the National Committee on Mental Hygiene, which ultimately evolved into the NMHA, now known as Mental Health America. This group performed and published surveys of state hospitals and patient treatment and treatment conditions and proved instrumental in changing conditions in state hospitals across the nation (Beers 1981).

In the late 1940s, a clubhouse model of psychosocial rehabilitation burst on the scene in New York City. Based on the belief that those with mental illness were capable of helping each other, the Fountain House (detailed in chapter “[Fountain House and the Clubhouse Movement](#)”), a membership organization run for and by persons with mental illness, was established. It aimed to achieve many things for its members that became the backbone of the principle of psychosocial rehabilitation: establishing relationships, increasing productivity and self-confidence, re-entrance into society, learning self-advocacy, and fighting stigma. It has spawned numerous

organizations locally and has served as a role model for many as they develop their own club house models ([Fountain House](#)).

The use of psychoanalysis to treat patients with neuroses blossomed in the 1930s and 1940s, and the creation of a veteran population afflicted by PTSD in World War II underscored not only personal vulnerability to horrendous stress but also the protective power of the unit (community) and incentivized the government to step up efforts at treatment ([Marlowe 1996](#)). See also chapter “[Veterans’ Services](#)” on veterans’ issues. Until the middle of the twentieth century, however, the systems of care for those with serious mental illness evolved slowly, and little significant progress was made towards actual treatment of mental illness; instead, the major focus continued to be segregation of those with mental illness from the general public. However, the mid-1950s and early 1960s were the beginning of a massive transition of those with serious mental illness back into the community. Although the introduction of the discovery and use of major tranquilizers (chlorpromazine) have often been touted as the major influence in de-institutionalization (movement of state hospitalized patients into the community), it is entirely possible that finances and politics were major players as well. [Grazier et al. \(2005\)](#) noted:

efforts to transfer responsibility/costs between and among agencies, states and the federal government, with persistent funding sources that were inadequate to meet the kind of resource and service needs of adults with serious mental illness... resulted in confusion, complexity in access to payment for services, created a burden on consumers and their families and disincentive from grass root providers to meet services needs... what developed was a lack of consistent national mental health policies... that led to a piecemeal financial system that diffused accountability, encouraged cost-shifting, and obscured service responsibility resulting in vulnerable populations being poorly served or abandoned. (p. 549)

State and federal legislation was passed that moved the development of *community*-based systems of care forward. In 1948 the National Mental Health Act created the National Institutes of Mental Health with the goal of supporting and sustaining innovative mental health-care pro-

grams and “scientific” treatment. In 1958, Congress passed the Mental Health Study Act, which was to “provide for an objective, thorough, and nationwide analysis and re-evaluation of the human and economic problems of mental illness” (Public Law 84-192). A resultant report (Action for Mental Health) delineated necessary funding, staffing, and treatment that President Kennedy used as a springboard to recommend a National Mental Health Program, calling for the building of two thousand mental health centers to provide comprehensive community-based programs to serve those with severe mental illness *and* adults, children and families suffering from stress ([Ewalt 1961](#)). In 1963, the Mental Retardation Facilities and Community Mental Health Center Construction (CMHC) Act was signed into law; unfortunately, proposed funding for staff was revised downward in 1965, and only substantial funding for the building of community mental health centers remained. Still, these centers were to provide both inpatient and outpatient services, consultation and education, and day treatment and crisis services. Centers serving rural areas and poor urban areas received additional funding. Worried that federal support would eventually disappear, there was some reluctance on the part of states to embrace these funds; by the time the program was terminated in 1981, only 754 catchment areas had applied for funding. It is worth noting that CMHC funding bypassed state authorities and was provided directly to local community authorities and agencies, since it was felt that states mostly provided inpatient services and that local community agency would be more responsive to the needs of local communities. Indeed, local communities were more interested in serving the larger number of people with common mental disorders rather than the smaller number of people with serious mental disorders served by state hospitals. As a result, many of these mental health centers focused care on those who were not seriously mentally ill. “These times reflected the beginning of a philosophical shift in treatment; psychiatric predicated care fell to psychologists, and effective interventions were thought not be medical or biologic in nature, but to be social or educational, and where it was prof-

ferred, that early intervention could prevent mental illness” (Feldman 2010, p. 194).

The passage of Medicaid and Medicare in the mid-1960s offered some provision of care and service, although these programs were not designed for patients with serious mental illness. Without continuous employment, SSDI was not available to these patients, and lower payment and higher co-pays existed for mental health until recently. IMD (Institution for Mental Disease) restrictions kept (and still keep) patients with Medicaid from accessing free-standing psychiatric hospital services, though there is considerable advocacy for such services to be paid for by Medicaid. Further elaborations on funding for mental health care are offered in chapter “[Financing of Community Behavioral Health Services](#)” concerning behavioral health financing.

Eventually hospital closures and/or downsizing meant the state hospital populations went from a high of over 558,000 to 62,000 in 1996. In spite of promised assistance with treatment, medication, housing, and vocational training, during the 1970s and 1980s, local mental health centers proved at best inconsistent in providing said treatment, and patients often found themselves facing “trans-institutionalization (placement in nursing homes, boarding homes, foster care, jails or prisons).

While President Nixon was successful in withdrawing some public support of mental health care, in 1977, President Carter empowered a Commission on Mental Health to review services and funding across the nation. It discovered that community services had increased over the last 15 years, but that substantial numbers of populations (ethnic minorities, the urban poor, women, children, veterans, those with physical handicaps, adults with chronic mental illness) were underserved, living without basic necessities, limited aftercare or medical care, and increased rates of hospital recidivism. The report encouraged the development of services for those with chronic mental illness, proposing federal grants for said development; the National Mental Health Service Systems Act of 1980 called for – and funded – a massive overhaul of the nation’s

mental health-care system to focus priorities on services for these underserved populations. Unfortunately, it was underfunded by President Reagan and by 1981 deleted entirely by the Omnibus Budget Reconciliation Act, decimating years of federal leadership, serving to further dismantle the regional impact of NIMH, and reducing staff and services at local mental health centers. Criteria for SSDI also changed then; while patients with serious mental illness made up 11% of SSDI recipients, they were 30% of those who lost program eligibility (Feldman 2010).

The 1980s and 1990s were also decades of imposition of managed care on the service provision for mental health patients in the community. Capitation systems were put in place, ostensibly to maintain quality services while controlling costs. Standardization of assessments and treatment, limited enrollment rates, risk-sharing, and external regulation (all often predicated on minimization of hospitalization) placed enormous burdens on local MHCs. But “managed care, which fostered a system in which choice was limited, care was managed to decrease costs, and continuity was threatened, was particularly troublesome for individuals with socially stigmatized, poorly understood illnesses that had traditionally been treated separately from standard medical care” (Feldman 2010, p. 196). Many state systems of care funded by Medicaid were decimated, and equivocal results from this experiment continue to be reported.

Declared the decade of the brain by President George H W Bush, the 1990s *did* reflect a revival in interest in biological treatment of serious mental illness and ushered in a plethora of new medications, including the atypical antipsychotic medications, which were touted as being superior to older antipsychotic medication; they did seem to have a reduced (though still present) probability of causing tardive dyskinesia, a dramatic movement disorder side effect. However, as a class they also carried with them a propensity for placing patients at risk for weight gain and development of diabetes, hyperlipidemia, and/or metabolic syndrome. While promising to enhance treatment, these new medications also imposed

huge financial burdens on formulary costs and “opened the door for massive influence by pharmaceutical companies” (Feldman 2010, p. 196). The Medicaid Rehabilitation option did encourage a focus on those with serious mental illness and encouraged development of a broader array of services by offering payment for supports such as case managers, day treatment, and ACT (assertive community treatment teams). Many mental health centers utilized Medicare funding to provide partial hospitalization services in an attempt to minimize hospitalization and rehospitalization. It should be underscored that the focus of treatment during this time was on symptom control.

By the early 1990s, there were limited tool kits to guide clinical interventions, primitive evidence-based practices, few nuanced outcome measures, and an increasing demand for service in the face of an under-developed psychiatric workforce. In response, the federal government in 1992 directed NIMH to be reorganized under NIH (the National Institutes of Health) to strengthen mental health-care research. At the same time, CMHS (Center for Mental Health Services) was moved under SAMHSA (Substance Abuse Mental Health Services Administration), to encourage and support workforce development. The philosophy of a community supports system was embraced. Forays into vocational rehabilitation blossomed. Psychosocial and psychiatric rehabilitation models were developed which emphasized the development of vocational rehabilitation plans; they focused on characteristics of work that were desired, the skills and knowledge necessary to perform the work successfully, the current level of readiness, and the methods to be used to help close the identified gaps (Wallace 1993; Lamb 1994; Liberman 1992). A wide variety of skills training (see chapter “[Psychiatric Rehabilitation](#)”), family psycho-education (chapter “[Family Systems Care in Public Sector Settings](#)”), and supported employment modules (chapter “[Supported Employment](#)”) have been developed since then. Barton (1999) reported that multiple programs focusing on empowerment, competency, and recovery had proven

helpful: “the range of social, educational, occupational, behavioral and cognitive training has improved the role performance of persons with serious mental illness, and noted an average of 50% decrease in cost of care due to reduced hospitalizations” (p. 526).

The report of the US Surgeon General in 1999 (US Department of HHS) denoted the gap between research and practice and made recommendations “emphasizing a scientific base, overcoming stigma, public awareness, adequate services, cultural competence, and real parity” (p. 467–8, Cohen et al. 2003). President Clinton’s attempt at health-care reform, which included parity between medical and mental health, proved unsuccessful. It was not until 2008 that Congress ultimately passed legislation requiring parity. More recently, tool kits and clinical guidelines have suggested evidence-based treatment interventions (APA practice guidelines), and since 2000 there has been an increasing push for the development of means to assess efficacy of treatment and the push for evidence-based practice (SAMHSA).

During the latter part of the 1990s and into the present, the major focus of treatment has shifted from symptom control to rehabilitation to recovery addressing needs of the whole person, “with the goal to help people pursue independence, self-management, personally meaningful activities and better quality of life” (p. 427, Drake et al. 2003). Core guidelines for recovery-oriented services included development of trusting consumer/professional partnerships less focused on hierarchy than on strength-based assessments, shared decision-making (Torrey and Drake 2010), psycho-education, relapse prevention, and consumer-centered treatment planning. Involvement and engagement with families as collaborators have occurred. NAMI’s use of family-to-family educational techniques has supported its efficacy (Mercado et al. 2016). Addressing co-occurring disorders (substance use/abuse/dependence and medical illnesses concomitantly with mental illness) is proving challenging, and yet without addressing these co-existing illnesses, patients will continue to be at higher risk for relapse and rehospitalization

(SAMHSA 2009). Cognitive behavioral therapy, dialectical behavioral therapy, and peer support (utilization of consumers as peer specialists, bridge programs) have offered consumers innovative therapies (see chapter “Peer Service Providers as Colleagues”) that can enhance recovery (Kart et al. 2021). As community providers seek to endorse and support rehabilitation and recovery, the use of assertive community treatment teams (see chapter “Case Management and Assertive Community Treatment”) reinforces and supports the skills sets necessary for recovery (Bond and Drake 2015). Attention to the imperative issue of stable housing (see chapter “Housing First and the Role of Psychiatry in Supported Housing”) has moved to the forefront, with multiple models of housing (dry vs damp vs wet; housing first, transitional housing, permanent housing) being attempted (Sylvestre et al. 2017). Utilization of telehealth (particularly during this era of COVID-19) has expanded capacity (see chapter “Telehealth and Technology”) to respond to the mental health needs of the community in a more timely fashion (Kopec et al. 2020). In addition, addressing the impact of social determinants and mental health equity on the development and maintenance of mental illness (see chapter “Social and Political Determinants of Health and Mental Health”) has come to the forefront of developing services for those living with mental illness (Compton and Shim 2017; Feldman 2020). Workforce development (or the lack there-in) continues to plague opportunities to plan expansions in access and treatment options (Hoge 2017).

Several salient court decisions have had a tremendous impact on the development of improved services for mental health patients. These are well summarized on a timeline in chapter “Advocacy in Evolution: The Push and Pull of Psychiatrists”. Suffice it to say, each federal ruling underscores the movement along the spectrum of the right to receive the least restrictive treatment by those committed to the states for mental health care. Recent court decisions (e.g., *Wit v United Behavioral Health*, 2019) reflect there continue to be people living with mental illness who experience discriminatory policies and

practices by insurance companies that restrict timely access to appropriate care.

Legislation continues to affect community psychiatry. The Medicare Modernization Act of 2005 proffered means by which those who had Medicare were able to purchase their medication, including psychiatric medication. In 2008 the Mental Health Parity and Addiction Equity Act Parity was passed that legislated that payment (and limits) for mental health and provision of mental health services (including substance abuse services) had to be essentially equivalent for medical and mental health care. Despite concerns that costs would rise precipitously, research reflects little impact on utilization, cost, or quality of care (Azzone et al. 2011). Of note, final rules for the Parity Act were not released until November 2013, and industry research still reflects considerable discrepancies in behavioral health access, provision, and reimbursement (Davenport et al. 2019).

In terms of mental health care, the passage of the landmark Patient Protection and Affordable Care Act (aka Obama Care, ACA) in 2010 expanded capacity of Americans to purchase health insurance; by law, behavioral health-care services were required to provide certain benefits. The ACA originally included Medicaid expansion for all states, but the US Supreme Court made Medicaid expansion voluntary. If states chose to expand Medicaid, this in turn expanded access to mental health services. Millions have been able to do so (Beronio et al. 2014) though there are still millions without access, particularly in states that did not expand Medicaid eligibility.

Almost 20 years ago, in 2003, President George W. Bush assembled the New Freedom Commission on Mental Health. This group of health-care practitioners were empowered to survey services across the United States, identifying programs that were particularly successful: “It reviewed the science of mental health, and mental health services, and offered an indictment of the mental health service system, which included fragmentation/gaps in care for children and adolescents, increased unemployment and disability (in those with SPMI) and noted that neither men-

tal health nor suicide prevention were a national priority.” Many, many examples of successful programs were highlighted. The commission recommended six general goals: (1) mental health is essential to overall health; (2) mental health care should be consumer/family driven; (3) disparities (like funding and access) had to be eliminated; (4) early mental health screening assessments/referrals needed to be common; (5) quality care should be delivered and research increased; and (6) community mental health should enhance the use of technology (Grob and Goldman 2007). No monies were attached to the report or its recommendations, so the report’s capacity to provide tangible influence to support evidence-based practice was limited. To its credit, the federal Center for Medicaid and Medicare Services embraced and promulgated a mantra of moving science into service and has focused funding on that research which could do so.

There have been other changes over the last 10 years that have significantly impacted those living with mental illness:

1. Engagement with the criminal justice system (GAP Committee, Psychiatry and the Community 2016). Educational training for law enforcement and the judiciary, innovative diversion policies, and treatment instead of incarceration are some of the strategies that are being utilized to enhance safe, recovery-oriented engagement and treatment (see chapter “Collaborative Reduction of Criminal Justice Involvement for Persons with Mental Illness”).
2. Programs that enhance the identification and recovery-oriented treatment for those with first-episode psychosis have been established nationwide (see chapter “Early Psychosis and the Prevention and Mitigation of Serious Mental Illness”).
3. In the face of climate change devastations such as drought and famine, storms, and wildfires that are already striking in all regions of an unprepared world, climate change is rapidly becoming acknowledged as the existential threat to humankind. In turn, mental health consequences of climate change are finally

being recognized and assessment and treatment options considered (see chapter “Climate Change: Impact on Community Mental Health”).

As the third decade of the twenty-first century progresses, multiple determinants are converging on the provision of mental health care. It is no longer acceptable to believe only prescribed medications are the sole considerations in the treatment of serious mental illness. Instead the hierarchical relationship of physician to patient must evolve into one of partnership, predicated on consumer strengths and self-defined desires for recovery goals. Easy-to-access evidence-based recovery-orientated services that address social determinants and mental health equity must be organized, funded, and coordinated and the consumer supported in the community. Stigma continues to hold powerful sway over lawmakers and common citizens, and society, health administrators, and financial systems have withheld adequate funding and service for centuries. By understanding the history of neglect and abuse of those living with mental illness, community psychiatrists can embrace the role of advocate and push to surmount the extant disparities in our systems of care to enable an evolution towards an embrace of and support for recovery: “to achieve the promise of community living for everyone (with) new service delivery patterns and initiatives that ensure every American has easy and consistent access to the most current treatment and best support services” (New Freedom Commission 2003).

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Part II

The Basics: The Pillars of Community Psychiatry