Hunter L. McQuistion
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Handbook of Community Psychiatry

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Dedicated to all community psychiatrists: our colleagues—past, present, and future—serving tirelessly to advance quality, compassion, knowledge, and equality.

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Part I

Introduction and Background

The Present and Future of Community Psychiatry: An Introduction

1

Hunter L. McQuistion, Wesley E. Sowers, Jules M. Ranz, and Jacqueline Maus Feldman

This book aims to be a practical guide to twenty-first century community psychiatry. While academics have well traversed the territory of community mental health over the past decade, the most recent comprehensive book specifically focusing on American-based community psychiatry was published in 1996 (Vaccaro and Clark 1996). A long time coming, our volume owes tribute to and builds on the important contributions of many other works characterizing the principles and practices of community psychiatry. In this book, we amplify these works by describing five central pillars of community psychiatry. These pillars focus on the practice of contemporary community psychiatry, further organizing the discipline's ideals, science, and craft. But in addition to simply organizing an ever expanding fund of technical knowledge, because psychiatry, and especially community psychiatry, is so sensitive to social mores and economic flux, this volume also seeks to accomplish a timely reevalution of community psychiatric practice.

The rapid evolution of healthcare delivery is a key illustration. As of this writing during early spring 2012, global economic stress is producing dramatic systemic changes in the United States. In this context, the 2010 Patient Protection and Affordable Care Act (ACA) is unfolding, with a new reorganization of services into so-called health homes that might serve a multiplicity of tailored clinical needs. Simultaneously, on the level of basic clinical care, approaches that incorporate the still-developing concept of personal recovery in mental health have emerged. Embraced by a broad mental health consumer movement, from whence the original concept emerged, it is validating the work of many community psychiatrists and now influencing other behavioral health practitioners. Resultant clinical practice deemphasizes the societal assumption in recent decades that advances in medical technology, such as pharmacology, yield the best results

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and provide the base for the future of psychiatric care. Instead, a heightened understanding of person-centeredness is coming to light, refocusing on what a helping relationship can offer, while still applying scientific developments, such as those in psychiatric epidemiology, to help design practices that could eventually become evidence-based, thus further refining technique, particularly in the context of an increasing demand for documented clinical outcomes.

However, in addition to being a critically needed update, we believe that the project of constructing this *Handbook* documents a maturation of the discipline of community psychiatry. To start with, community psychiatric practice takes place in publicly funded organizational settings and there are an increasing number of psychiatrists working in these environments, highlighting a trend away from traditional private practice. As of 2002, early career psychiatrists were working 50% of weekly hours in publicly funded settings, as opposed to 17% in solo practice, with midcareer psychiatrists working 44 and 29% of their time, respectively, in these settings. This was an increase in the proportion of organizational vs. solo practice settings from 1996 at which time early career psychiatrists' reported 40% vs. 22%, 40%/22%, and midcareer psychiatrists reported 29% vs. 36% (Ranz et al. 2006). Similarly, though the process of development is ongoing (Sowers et al. 2011), chief executive officers of community-based behavioral health organizations have increasingly valued the role of medical director after several decades during which psychiatric collaboration was frequently minimal (National Council of Community Behavioral Healthcare 2011; American Association of Community Psychiatrists 2011). As described by Ranz in Chap. 48, the number of community/public psychiatry fellowship programs appears to be increasing, with 14 current programs, evidencing the appreciation of need for a sophisticated corps of psychiatrists able to work in American community-based settings, both traditional, such as community mental health centers, and nontraditional, such as not-for-profit programs outreaching to marginalized populations, such as people who are homeless. The new emphasis on integration and primary care increases the demand for a psychiatric workforce that can meet these challenges. Additionally, because of inclination, training, and experience, many community psychiatrists are also recognized as expert in working within systems. Accentuating its relevance, competency in systems-based practice is increasingly identified as a critical part of general psychiatric training (Accreditation Council for Graduate Medical Education 2007) with community psychiatry faculty therefore having a unique offering in building competency.

So, if community psychiatry has come of age as a discipline, with identifiably useful expertise to offer the profession and the entire mental health community, *a definition of just what it is* requires discussion. As far as back as 1963, there have been at least ten definitions of the evolving subspecialty (Szmukler and Thornicroft 2001; Jacobs 2011). We believe that the range and diversity of these proposed definitions reflect a reality that, as an area of defined expertise, community psychiatry has been a work in progress at least since the beginning of the 1960s, and the breadth of what self-identified community psychiatrists do is so broad, from academic work and public policy-making to a wide range of clinical endeavors, we are not surprised that an apparent cornucopia of definitions have been formulated, each accentuating an aspect of the work. Adding some complication to this has been the companion term, "public psychiatry." As discussed in detail in Chap. 48, while "public psychiatry" may not be wholly interchangeable with "community psychiatry" as a specialty, this moniker is frequently used to emphasize the tendency for community psychiatrists to work in publicly funded systems.

The 1985 founding of the American Association of Community Psychiatrists (AACP) (http://www.communitypsychiatry.org/default.aspx) has been an initial important step in coalescing professional identity. This organization has been a reference point within American psychiatry for collegial support, education, and the development of policy that reflects modern community mental health care. Endorsed by the AACP in 1993, Brown et al. (1993) articulated that community psychiatry is

> …a branch of psychiatry which emphasizes the integration of social and environmental factors with the biological and psychological components of mental health and mental illness. Community psychiatry is also a significant component of the more inclusive field of community medicine which focuses broadly on the prevention and treatment of illness for all individuals in a given community.

In 2001, Szmukler and Thornicroft analyzed the various definitions in great detail and emerged with a definition that they further refined in 2011 (Drake et al. 2011) in order to encompass "community mental health care."

> Community mental health care comprises the principles and practices needed to promote mental health for a local population by:
>
> 1. Addressing population-based needs in ways that are accessible and acceptable
> 2. Building on the goals and strengths of people who experience mental illness
> 3. Providing a wide network of supports, services, and resources of adequate capacity
> 4. Emphasizing services that are both evidence-based and recovery-oriented

Because this *Handbook* purposefully builds on prior work, we endorse these definitions, together, as complementary descriptions of community psychiatry. The former is global in scope, appropriately accentuating public health and the overall health of communities, otherwise termed the "macrosphere" (Rosen 2006). The latter definition denotes a focus on populations and the provision of effective resources to create accessible service systems that are oriented to assisting people to use their own strengths in pursuit of mental health. In this *Handbook,* we describe five central pillars of community psychiatry built on the two complementary definitions. These pillars focus on the practice of contemporary community psychiatry, further organizing the discipline's ideals, science, and craft.

Parts I and II: Introduction and Central Pillars

After the conceptual introductory chapter you are now reading, Jacqueline Maus Feldman's chapter recounts the historical evolution of community psychiatry. The five pillars are then discussed in detail in the *Handbook's* Part II ("The Basics: Central Pillars of Community Psychiatry") as separate chapters with real-life practical applications. Woven and often cross-referenced into subsequent chapters throughout the book, the pillars of Epidemiology, Public Health and Prevention, Financing, Advocacy, and Recovery and Person-centeredness are summarized as follows:

Epidemiology. Because the work of community psychiatry is necessarily population-focused, epidemiology arguably represents its matrical "basic science." As authors Dana March and Ezra Susser note in their chapter, "epidemiology helps provide an evidence base for community psychiatry, with an eye, ultimately, toward intervention." This chapter explains psychiatric epidemiologic methodology, describes key studies, and points to how identifying and ordering a multiplicity of causes give clues for interventions.

Public Health and Prevention. Characterizing the work of community psychiatry on a macrolevel entails viewing the work as public service, elevating community well-being. This phase of community psychiatry resonates with its commitment to reducing health disparities and, on a clinical level, promoting health education to enable people to feel in highest command of their wellness and recovery processes. In this chapter, Michael Compton describes the processes and challenges for community psychiatrists to exercise skills in prevention and in promoting public health.

Financing. Without funding, healthcare quite simply does not happen and because the bulk of community psychiatric service operates through public funding mechanisms, with inevitable political vicissitudes, it is necessary for all community psychiatrists to understand how cash flows. Without this understanding, practitioners—and the people they serve—are vulnerable to an erosion of empowerment to optimize service and outcomes. Anita Everett and her coauthors describe the basic mechanics of current financing, while also noting possible future trends, such as the ACA noted above, and how these trends might affect behavioral healthcare.

Recovery and Person-Centeredness. As we have mentioned, the emergence of the recovery movement and the resultant new emphasis on person-centeredness is arguably the most dramatic shift in clinical approach over the last decade. Wesley Sowers describes the current development of this concept and how it will continue to influence practice and policy.

Advocacy. Community psychiatrists have a tradition of working with underserved and marginalized populations, requiring them to be advocates for their patients, either on an individual basis in such activities as helping to access supportive housing, in facilitating service with other healthcare professionals, in working within organized medicine to influence legislation and public health policy, or in clinical administration, leveraging for improved services. Advocacy has always been at the heart of the subspecialty and is thus included as a pillar. Jeffrey Geller discusses the history of advocacy and the latter day issues it presents to community psychiatrists as they struggle, together with consumers and their families, with systems that are frequently suboptimal in responding to quality service and community well-being.

Part III: New Emerging Keys to Practice

Because we as editors are concerned both with community psychiatry as it exists today and committed to ensuring its future, Part III covers New Emerging Keys to Practice: those we believe will influence the way community psychiatry, and related practice environments, will move forward in coming years. These keys include general approaches to services, as well as innovative population-based clinical approaches and techniques. In the context of person-centeredness, it is fitting that Kenneth Minkoff's and Christie Cline's chapter on the Welcoming Service Environment begins this section, outlining how even very basic and apparently simple interventions in a service environment can profoundly help outcomes. We follow this with a chapter concerning person-centered treatment planning, by Neal Adams and Diane Grieder. This chapter expands on practical aspects of recovery-orientation, helping clinicians transform formal treatment planning into a collaborative and useful endeavor, particularly considering how the treatment plan has historically been reduced to being a regulatory ritual in many public sector settings. Paolo DeVecchio follows this with his discussion of Peer Service Providers as Colleagues, explaining how community psychiatrists can help enable self-identified peer clinicians integrate into the treatment team, in turn greatly strengthening service delivery. While peer clinicians represent a new human resource in behavioral healthcare, Avrim Fishkind and colleagues discuss the rise of electronic technology. This chapter describes, in Telepsychiatry and e-Mental Health, how these media are particularly relevant to psychiatry and how community psychiatrists will work in the future.

The last three chapters of Part III cover important, and expanding, treatment approaches. Paula Panzer and her colleagues cover how personal trauma history, increasingly recognized as ubiquitous, particularly in disaffiliated and impoverished populations, requires focused clinical attitude and approaches. Michael Garrett describes the emerging recovery-oriented technique of cognitive therapy specifically aimed at schizophrenia, offering new sources of hope for this population. Finally, David Pollack and his coauthors highlight the rapidly emerging role and techniques for psychiatrists in integrating primary care and behavioral health, long championed by many in community psychiatry and finally being adopted by policymakers.

Part IV: Practicing—Core Clinical Competencies and Techniques

Part IV of the *Handbook*, "Practicing: Core Clinical Competencies and Techniques" highlights eight basic competencies in a community psychiatrist's armamentarium. Russell Lim launches the section with the essential skill of cultural competence. Cultural competence is not only at the foundation of any population-based clinical intervention, but

as multiculturalism and American society are increasingly synonymous, it has critical application to generic behavioral health care. Clinical tools that must follow from this are described by Steven Goldfinger's and Jacqueline Maus Feldman's discussion of how clinical evaluation is always shaped by the setting in which it is performed. Igor Koutsenok then offers a full description in Motivational Interviewing about how knowing this technique, which should be viewed as second nature to psychiatrists, offers pathways to help patients move themselves along a line of motivation for change.

Because of the frequent complexity of a person's clinical presentation, the treatment team, a fundamental functional unit in community psychiatry, is dissected in detail by Carl Bell and his colleagues. As an outgrowth of this, while psychiatrists are not usually experts in the provision of all phases of psychosocial rehabilitation, relying on other team members, such as occupational therapists, to bring these techniques to full fruition, Richard Warner surveys the field and points to how community psychiatrists must have serious knowledge of technique and application of rehabilitation principles, integrating these approaches into practice. In a related manner, socially based clinical techniques are close to the heart of community psychiatric practice. Leslie Hart Gise and Benjamin Crocker describe how group techniques can be used for optimal outcome and Alison Heru's chapter, Family Treatment in Public Sector Settings, reminds us how we can foster change by approaching the core social group, the family. Richard N. Rosenthal then helps us begin to address another ubiquitous issue in community psychiatric practice, cooccurring substance use and mental health disorders (COD), carefully laying out basic techniques to work with this clinical issue.

Part V: Tried and True—Major Evidence-Based Practices

Part V, "Tried and True: Major Evidence-Based Practices," covers major universally accepted evidence-based interventions. While "all community psychiatry is local," the challenge is for practitioners and programs in community mental health to employ and adapt these interventions to their local service environments, matching them with appropriate populations. The section begins with a transition from Richard N. Rosenthal's chapter on basic COD techniques in Part IV to a comprehensive survey of evidence-based interventions by Christine Yodelis-Flores and her coauthors. This is followed by an exposition of Assertive Community Treatment, with a comparison to other forms of case management by Richard Gosche and colleagues, with subsequent descriptions of the supported employment model (Kim T. Mueser and Gary R. Bond), Behavioral and Physical Self-Management (Anthony J. Salerno and Paul J. Margolies), Psychopharmacology and Medication Adherence, with particular focus on how medication aids in the recovery process (Ron Diamond), and finally, a multifaceted discussion of family psychoeducation by Susan Deakins and William McFarlane.

Part VI: Heroes—Promising Practices and Interventions

Whereas evidence-based practices (EBPs) are well established, there are also other "Heroes: Promising Practices and Interventions," as explored in Part VI. These chapters discuss interventions that are either just entering into the realm of being EBPs, hold high creative promise in doing so, or represent approaches not typically identified with American mental health care. It is led off by Sam Tsemberis and colleagues' in-depth discussion of approaches to supported housing, concentrating, as well, on the role of psychiatrists in these programs. It is followed by Alan Doyle's description of the Fountain House psychosocial clubhouse model and its relationship to community psychiatry. Deepika Sabnis and Rachel Lipson Glick then examine community-based crisis services and hospital alternatives—increasingly important in an era of fiscal belt-tightening. And because we hope the *Handbook's* material is useful beyond the systems born in the United States, to the global

"community" of community psychiatrists, Alan Rosen and his colleagues have reported on the status of behavioral health interventions internationally. These, in turn, could inform policy and seed initiatives in elsewhere on the globe.

Part VII: Applied Public Health—Special Populations

Here is where psychiatric epidemiology most clearly relates to practice. Through its population-based orientation, community psychiatry has developed evolving models of service to special populations that are underserved by traditional behavioral health services. Arguably, this has quintessential embodiment in homeless populations, as discussed by Hunter L. McQuistion in this section's first chapter. The chapter also notes established and emerging practices, such as Critical Time Intervention, that have themselves influenced broader behavioral healthcare. Following this is Fred Osher's description of public health issues and diversion strategies concerning a phenomenon of transinstutionalization—people with serious mental illnesses, mostly those without social supports, being relegated to the criminal justice system. Mathew N. Goldenberg and colleagues then extend Paula Panzer's discussion of trauma in Part IV to this century's newly realized skill-set, managing the psychiatric sequelae of disasters and their effect on communities. Susan Rathmell and her coauthors go on to describe the mental health issues of veterans and their families entwined by a currently ever-growing reality of combat experience. Ronald Hellman then discusses Clinical Issues and Programming for Lesbian, Gay and Transgender Populations, emphasizing how these populations have special needs and strengths, requiring special cultural competence.

The following two chapters of Part VII survey both ends of the life cycle: how community psychiatric approaches lend special value to practice among children and adolescents (Charles Huffine) and elders (Carl Cohen and Fayez Ibrahim). Finally, community and public psychiatry is often associated with urban environments, yet Paulette Marie Gillig and colleagues end the section by examining the challenges of delivering quality community-based care in rural settings.

Part VIII: Making It All Work—Systems and Administration

The practice of community psychiatry is inextricably connected to systems, whether as "micro" as a treatment team in a public shelter or as "macro" as a state mental health system. In order to succeed, it is necessary for community psychiatrists to not only understand how to work within systems, but to adaptively exploit them for their patients, even if as clinical psychiatrists they are without direct administrative or policymaking roles. Anita Everett and colleagues' "Pillars" chapter in Part II on Financing lays groundwork and this section fully elaborates on understanding how systems function. It begins with Michael Hogan's description of the process and lessons of leading the President's New Freedom Commission on Mental Health as related to the essential leadership task of rethinking and transforming services. There is a role for psychiatry in leadership and Jacqueline Maus Feldman's following chapter on this topic offers valuable tools to achieve this. Wesley Sowers then leads us into the related discussion of the art and science of resource management and services administration, logically transitioning to Stephen Rosenheck's and Jules Ranz's chapter on the evolving role of the medical director in community mental health.

The final chapters of this section discuss two other important and emerging facets of clinical administration. As Robert Savage and his colleagues describe in their chapter, Program Evaluation and Quality Management, the demand for measurable outcomes is advancing inexorably, along with skills acquisition in quantitative quality management, such as continuous quality improvement. As watchdogs in quality person-centered care in publicly funded behavioral health, it is indispensable for community psychiatrists to understand this. On a more involved level, this moves to expertise in services research, as Mario Cruz discusses next, enabling community

psychiatrists to comprehend how using rigorously derived evidence can further legitimize clinical intuition and experience.

Part IX: Shaping the Future—Education, Workforce, and Professional Development

An absence of training and education yields no future and we are at a time when the workforce in behavioral health does not meet public need, particularly with psychiatrists in short supply. Part IX discusses current issues and opportunities in the training and building of a cohort of community psychiatrists. The accent is on extending the reach of traditional training and education, preparing psychiatrists to thrive in an evolving service environment. Kathleen A. Clegg speaks to issues in current medical school curricula, proceeding to suggest modifications that better prepare medical students to manage systems-based treatment and then discusses approaches to residency training with concentrations in community psychiatry. Jules Ranz describes the growing range of postresidency fellowships in public and community psychiatry, an optimistic harbinger of the discipline's future. Perhaps at the core of psychiatric training is the role of the mentor. Joel Feiner articulates how mentoring and supervision can be applied for support during all phases of a professional career, helping us to be enlightened colleagues. Finally, H. Steven Moffic and Herb Bateman discuss ethical issues in community psychiatry and offer policies and procedures to guide practice.

Welcome to the Future: We're Glad You Made It[1]

In an important sense, the future begins at the moment of reading this sentence.

It presents a challenge and an opportunity. Practice in community behavioral health will undergo reorganization over the next decade. Sufficient economic resources, always tough to acquire in the public sector, will become even more difficult to adequately capture at least in the near future. The field will gear itself to measurable outcomes using services and clinical technology. Simultaneously, program survival will depend on being as economical as possible, likely leading to "pay for performance" methodologies. This will require financing strategies that hold hope for efficiency yet combined with true person-centeredness, including some forms of capitation (see Chap. 5), as well as the development of medical homes with optimally integrated behavioral health, along with an increased use of peer workers (who are both economical and recovery-oriented).

As Jacobs (2011) points out, the ACA operationalizes a vision of dramatically increased ranks of Americans with health insurance, leading to a growing need for human resources in behavioral healthcare—even as available workers in the field are now at a premium, especially psychiatrists. Meeting this human resource need requires community psychiatrists to be confident of their knowledge and skill, even as they garner support from organizations like the AACP. To further assist in this effort, helping the discipline reach the next phase in development, AACP has launched a methodical process to create a formal competency certification in community psychiatry. We hope this book is an important additional tool equiping all psychiatrists to work effectively in any clinical, administrative, policymaking, or academic role within systems of behavioral healthcare.

As noted, and as you will see detailed throughout this book, community psychiatry with its allied colleagues, has an opportunity to not only continue to adapt, but we believe, thrive, as behavioral health resources move to newer models.

An important example arises from the concept of the medical or health home, whose creation increases focus on primary care and prevention. Our view is that there will be increasing opportunities for community psychiatrists to advance their special skills in negotiating systems so as to catalyze greater integration of health and human services toward improving the

[1]The Firesign Theatre, 1971

wellness of whole communities. While it is unquestionable that psychiatrists will need to show that they are contributing to results-based productivity, they can help show the way, leading the psychiatric profession, and medicine in general, as they use knowledge derived from the Central Pillars and the tools the *Handbook* offers. In this way, the *Handbook* can add strength to a community psychiatrist's dedication and experience, helping each one of us to become the authors of the future.

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History of Community Psychiatry

2

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 comprehending 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 life style, 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 of trusting counseling relationships and developed patient-centered, supportive asylums from 700 to 200 AD (Million 2004). Unfortunately, such forbearance was not as

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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" (Million 2004, 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, 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, shipped off 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. Toward the end of the 1700s, the moral treatment movement occurred, with leadership provided by Phillipe 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 word, 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 sixth century Dimphna, 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 3,800 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 healthcare 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 are mentally retarded, over 20% 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).

Unfortunately, communities like Geel were 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 impoverished); 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, 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 Chap. 30), 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-entry 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 2011).

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 2001). See also Chap. 36 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

toward 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) has 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 healthcare programs 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 2,000 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 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, 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. In addition, many of those staffing 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 proffered, 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. Further elaborations on funding for mental health care are offered in Chap. 5 concerning behavioral health financing.

Eventually hospital closures and/or downsizing meant the state hospital populations went from a high of over 5,50,000 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