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Community psychiatry in the United States 50 years after the Community Mental Health Centers Act

H. H. Goldman, *Guest Editor** **and M. Tansella**, *Editor*

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The glass half-full is still half-empty, but it need not remain so

The two editorials written for this issue of EPS reflect seemingly different views on the 50 years since President Kennedy signed into law the Community Mental Health Centers Act in the United States. However, both Lisa Dixon and Michael Hogan point a similar direction for the future for the US and for other countries. Dixon reports on advances in treatment and implementation of evidence-based mental healthcare, particularly over the past decade. Hogan provides a vision of the future addressing the limitations in our system of services, in spite of the advances reported by Dixon. Both see a brighter future building on the successes of the past 50 years.

We editors are partnering for this set of editorials, just as we have agreed to partner with our two journals, *Psychiatric Services* and *Epidemiology* and *Psychiatric Sciences*, agreeing to share our Table of Contents with one another. It is a partnership built on a new collaborative spirit between two like-minded souls, working on opposite sides of the Atlantic, hoping to make our field stronger by publishing editorials and research reports on mental healthcare services. We hope that these publications will help to improve the services provided to make them as good as they can be. It is in that spirit that we commissioned two outstanding thought leaders to prepare these papers on this important anniversary. We selected these two authors, among other reasons, because Dixon had written previously on the 40th anniversary of the Community Mental Health Act (Dixon & Goldman, 2003), and at about the same time, a decade ago, Hogan had chaired the President's New Freedom Commission (2003), which had reviewed the mental healthcare service system in the US.

A bit of history – a bit of reflection

In the United States, the Community Mental Health Centers Act marked a significant shift in policy and in the organization and financing of mental healthcare services. It was a federal law introduced into a policy arena that had been mostly the domain of States and localities for both public and private funding, insurance regulation, licensure and direct provision in the public sector. The federal government was involved in mental healthcare only through its responsibility for services in the capital, Washington, D.C., and the armed services and veterans' health systems. Otherwise, mental healthcare was either a private responsibility or a State or local governmental responsibility with State Care Acts in every jurisdiction. The entry of the federal government into mental healthcare services ushered in a new era of community mental healthcare.

The shift from institutional to community services as the main locus of mental healthcare was a long, drawn out process in the US. It involved slow changes in patterns of hospital care and the expansion of ambulatory services. World War II had provided several important mental healthcare lessons. Medical examinations at the time of enlistment and induction into the armed forces revealed the prevalence of mental impairments in the general population, and suggested the importance of prevention of mental disorders and a public health perspective on mental healthcare. Combat medical care experiences in the war provided examples of the importance of short-term mental healthcare services delivered on the front lines, where soldiers experiencing acute stress responses could be returned to their units by avoiding evacuation and long-term hospitalization. This gave rise to a short-term inpatient and outpatient treatment approach to serve as an alternative to long-term inpatient care, which came to be known as community care. (Grob & Goldman, 2006) Civilian mental healthcare leaders also learned lessons during the war years. Erich Lindemann, a Harvard psychiatrist who wrote about the organized treatment of acute stress in survivors and first-responders to the tragic Cocoanut Grove fire, established the first mental healthcare service called a community mental healthcare center at the Human Relations Service in Wellesley, Massachusetts in 1948. (Mora, 1967).

The new emphasis on outpatient treatment in community settings was paralleled by changes in hospital

* Address for correspondence: Professor H. H. Goldman, University of Maryland School of Medicine, 1501 South Edgewood Street, Suite L, Baltimore, MD 21227, USA.
(Email: hh.goldman@verizon.net)

psychiatry. Length of stay dropped dramatically reducing the number of beds needed for acute care and patients were discharged from long-stay beds in hospitals to nursing homes and other types of care homes in the community. In some instances, patients were released prematurely to no proper care in the community, when patient links to their families and old neighbourhoods had been disrupted by long stays in hospital. The process, called deinstitutionalization, developed a bad name for the haphazard way in which it was implemented in some parts of the US and elsewhere. Some referred to the transfer to other institutional settings, such as nursing homes as 'trans-institutionalization.' It is worth mentioning that deinstitutionalization was not the key element of the Community Mental Health Act, which called for hospitals to reorganize and focus more on acute care in general hospitals. At times, however, advocates for community services argued that ambulatory services would render hospitals unnecessary. The tale is complex and beyond the scope of this editorial, but the dual processes of deinstitutionalization and community care spread around the world.

In other countries, the locus of reform varied from nation to nation. In Italy, for example, it came at the end of the 1970s with the reform laws, which originated in the north in Trieste and in the centre in Arezzo. The psychiatric reform was approved in May 1978, was national and became part of the law that created the National Health Service (approved in December 1978). The emphasis was on integration of hospital services with the rest of the community. New services were designed to be an alternative to previous long-stay psychiatric hospitals not complements to them. Reformed Italian community mental healthcare services were easily accessible, population-based and multidisciplinary. They offered acute care and crisis services and provided domiciliary care in the community. (Tansella & Williams, 1987) In the UK., the changes were national and followed on reforms to the National Health Service. Community mental healthcare teams cared for individuals outside hospital settings. The approach was population-based with defined geographical catchment areas and a centralized planning of mental healthcare services within the NHS. On the other hand, social welfare services remained a matter for local government, and tensions arose between national and local authorities over care of individuals with severe and persistent mental health conditions living in community settings. (Milbank, 1962) All over the world during the past half century, the evolution and reform of mental healthcare services reflects the interplay of centralized and decentralized actors and agents at work in shaping mental healthcare services policies.

In every instance, the reforms were the process of an interaction between incremental changes in policy and practice and a larger vision of fundamental change. The Community Mental Health Centers Act was born of a wish for fundamental change in service delivery, favouring prevention and mental health (rather than mental illness). The reality, however, was that change over the following decades was mostly incremental and opportunistic. (Grob & Goldman, 2006)

The editorials

Dixon focuses on clinical care and programmes. Hogan focuses on policy and organizations. By providing an update on the Schizophrenia Patient Outcome Research Team treatment recommendations, Dixon emphasizes the expansion of evidence about the effectiveness of services. She conveys a sense that our field is moving forward and getting better. Hogan recognizes these advances but reflects concern that necessary resources are not available to fuel these effective services. He sees a system 'in shambles' as the presidential commission he chaired concluded, unable to implement the advances described by Dixon. Both recognize the deficiencies, but both of them see the potential for growth, particularly in new, early intervention services.

Dixon focuses on speciality care, and Hogan focuses on the mainstream of healthcare and social services. On using the perspective of cycles of reform, Dixon sees the opportunities of first-episode psychosis services as a way of returning to the basic optimism of the community mental healthcare movement, rooted in speciality psychiatric services. In the best of all possible scenarios, she hopes that these specialized, early intervention services will alter the course of major mental disorders, reduce the duration of untreated psychosis and prevent disability. However, even in the short run, these speciality services offer symptom reduction and social participation in school and work. Hogan looks to mainstream services for the opportunities. He sees primary care settings and the schools as places to improve case identification and to introduce evidence-based treatments. He is realistic about the difficulties associated with implementing such innovations in mainstream settings, but he is hopeful that this is the wave of the future. Much will depend on our ability to implement effective services in either speciality psychiatric services or mainstream healthcare services or beyond in the schools, workplaces and other human service sectors where so many individuals experience mental impairments that go unrecognized and untreated.

The best is yet to come

It is hard to avoid the fact that needs continue to grow even as resources have declined during the Great Recession. For example, some communities report a decline in available beds and a contraction of resources for services. On the other hand, some innovation continues, such as the expansion of first-episode psychosis and other early intervention services.

Whether one sees the glass as half empty or half full, it is hard not to marvel at the accomplishments of the past 50 years in community mental healthcare. We hope these editorials encourage better things for our field, knowing that so much more can be accomplished.

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Conflict of Interest

None.

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