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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, Dorothea 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), Dorothea 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 NIMH, 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

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 healthcare 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 HW 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 underdeveloped psychiatric workforce. In response, the federal government in 1992 directed NIMH to be reorganized under NIH (the National Institutes of Health) and CMHS (Center for Mental Health Services) to be moved under SAMHSA (Substance Abuse Mental Health Services Administration), which sought to encourage and support mental healthcare research and workforce development. The philosophy of a community supports system was embraced. Forays into vocational rehabilitation blossomed. Psychosocial and psychiatric rehabilitation models were developed by William Anthony and his colleagues 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, family psycho-education, and supported employment modules have been developed since then (see Chap. 25 covering supported employment). 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 U.S. Surgeon General in 1999 (U.S. Department of Health and Human Services 1999) 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” (Cohen et al. 2003, pp. 467–468). President Clinton’s attempt at healthcare 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 increasing support for the development of means to assess efficacy of treatment and the push for evidence-based practice.

During the latter part of the 1990s and into 2000 and beyond, the major focus of treatment has shifted from symptom control to rehabilitation to recovery, “with the goal to help people pursue independence, self-management, personally meaningful activities and better quality of life” (Drake et al. 2003, p. 427). Core guidelines for recovery-oriented services included development of trusting consumer/professional partnerships less focused on hierarchy than on shared decision-making, psycho-education,

relapse prevention, consumer-centered treatment planning, and strengths-based assessments. Involvement and engagement with families as collaborators has occurred. NAMI’s use of family-to-family techniques has proven dramatically its efficacy. 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. Cognitive behavioral therapy, dialectical behavioral therapy, and peer support (utilization of consumers as peer specialists, bridge programs) have offered consumers innovative therapies that can enhance recovery. Community psychiatry has entered an era that seeks to endorse and support rehabilitation and recovery, often increasing the use of assertive community treatment teams to reinforce and support the skills sets necessary for recovery. Attention to the imperative issue of stable housing has moved to the forefront, with multiple models of housing (dry vs. damp vs. wet; housing first, transitional housing, permanent housing) being attempted.

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 time-line in Chap. 6 on advocacy. 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 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 Parity Act 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). Healthcare reform, passed in 2010, offers a unique opportunity for the provision of mental health

care; however, ongoing challenges exist regarding the limitations of the mental healthcare workforce and the interface between mental health and primary care (please see Chap. 14 for detailed discussion).

In 2003, President George W. Bush assembled the New Freedom Commission on Mental Health. This group of healthcare practitioners was 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 mental health nor suicide prevention was a national priority.” Many examples of successful programs were highlighted. As detailed in Chap. 41, the commission recommended six general goals:

1. It must be understood that mental health is essential to overall health.
2. Mental health care should be consumer/family-driven.
3. Disparities had to be eliminated.
4. Early mental health screening assessments/referrals needed to be common.
5. Quality care should be delivered and research increased.
6. Enhanced use of technology (Grob and Goldman 2007).

Unfortunately, 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.

As the first decade of the twenty-first century draws to a close, two salient forces are converging on the horizon: an increasing understanding that medications are not the be-all and end-all in the treatment of serious mental illness (Angell 2011); instead, it is now being embraced that medications can be effective but unless recovery-orientated services are established (funded and

coordinated) and the consumer supported in the community, any success is fleeting. Stigma continues to hold powerful sway over law makers and common citizens, and financial systems (given the recession of 2008–2011) feel compelled to decrease funding for many things, including mental health. Perhaps the lives of those with mental illness can surmount the extant disparities to reach futures headed for recovery. These hopes are best summarized (though certainly not mandated or funded) by the President’s New Freedom Commission (2003): “to achieve the promise of community living for everyone, new service delivery patterns and initiatives must ensure that every American has easy and consistent access to the most current treatment and best support services.”

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