The community mental health movement in the U.S. peaked in 1963 with the passage of the Community Mental Health Centers (CMHC) Act. The movement had its origins in the two decades before 1963, beginning with World War II, and matured in the 20 years that followed. The CMHC legislation stood at the mid point of a cycle of reform, in the midst of a movement that profoundly altered services for people with mental illness. We discuss the origins of the community mental health movement, and elaborate on the next phase of the cycle of reform, from the late 1970s until the present. The focus is on the community support reforms that re-emphasized the care of individuals with severe and persistent mental illnesses. We intend to complement the paper by Saul Feldman, who primarily discusses the period of the maturation of the community mental health movement from 1963 until the 1980s. Our analysis uses the framework introduced by Morrissey and Goldman to describe “cycles of reform” in the delivery of U.S. mental health services. They describe a recurrent pattern of reforms marked by public support for a new environmental approach to treatment and an innovative type of care (Goldman, 2002; Goldman & Morrissey, 1985; Morrissey & Goldman, 1984; Morrissey & Goldman, 1986). The first cycle of reform in the early 19th century introduced moral treatment and the asylum (Caplan & Caplan, 1969; Grob, 1966, 1973; Rothman, 1971). The second
cycle in the early 20th century was associated with the mental hygiene movement and the psychopathic hospital (Deutsch, 1944; Grob, 1983; Quen, 1977; Rothman, 1980; Sicherman, 1980). Each innovation proved successful with acute and milder, not chronic, forms of mental disorder, yet failed to eliminate chronicity or to fundamentally alter the care of the severely mentally ill. In each of the first two cycles, the optimism of reform gave way to pessimism and nihilism toward the increasing numbers of incurable patients.

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The third cycle of reform, which emerged in the mid-20th century, supported community mental health centers as the optimal locus of care (Foley & Sharfstein, 1983; Joint Commission on Mental Illness and Health, 1961; Levinson & Brown, 1967; Musto, 1975). Beginning in World War II, several new ideas emerged. First, crisis intervention and community involvement were viewed as important due to psychiatrist Erich Lindemann’s experience with post-traumatic psychiatric care following the Coconut Grove fire (Lindeman, 1944). This experience led Lindemann to create the first community mental health center in 1948. A similar thrust arose from military psychiatric practices that involved rapid treatment at the front (i.e., within the “community” of combatants) and the return of transiently emotionally disabled soldiers into the line. The notion that the community could be the source of both the trauma and healing reinforced community practice, and provided the underpinnings of the rationale for the CMHC. This movement also took on issues of poverty, racism, civil unrest, violence, and criminality as threats to mental health (Faris & Dunham, 1939; Grob, 1994).

The first CMHCs were principally devoted to consultation and education for community agencies. Mental health professionals offered treatment to new groups of previously untreated, acutely ill, and emotionally troubled patients. Few persons with severe and chronic disorders were treated at the centers (Goldman & Morrissey, 1985; Grob, 1994).

Only later did they offer outpatient services and develop inpatient agreements with community hospitals. Facilitated by postwar optimism, and the introduction of antipsychotic and antidepressant medications in the 1950s, lengths of stay at state hospitals began to decline. The so-called movement towards “deinstitutionalization,” propelled by a variety of forces, was gathering momentum. Community mental health centers, often sponsored by state mental hospitals (as early as the 1950s), focused on ambulatory services, especially “aftercare” and crisis