Epidemiology and Psychiatric Sciences (2014), **23**, 337–344. © Cambridge University Press 2014
doi:10.1017/S2045796014000560

SPECIAL ARTICLE

Community psychiatry's achievements

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Mental health care in the second half of the 20th century in much of the developed world has been dominated by the move out from large asylums. Both in response to this move and to make it possible, a pattern of care has evolved which is most commonly referred to as 'Community Psychiatry'. This narrative review describes this process, from local experimentation into the current era of evidence-based mental health care. It focuses on three main areas of this development: (i) the reprovision of care for those discharged during deinstitutionalisation; (ii) the evolution and evaluation of its characteristic feature the Community Mental Health Team; and (iii) the increasing sophistication of psychosocial interventions developed to support patients. It finishes with an overview of some current challenges.

Received 30 May 2014; Accepted 6 August 2014; First published online 17 September 2014

Key words: Community psychiatry, Community Mental Health Teams, deinstitutionalisation, evidence-based care.

Introduction

Community Psychiatry developed as a response to deinstitutionalisation and the move of mental health care out from large mental hospitals. Inpatient numbers peaked in the mid-1950s and have been shrinking since from, for example, 150 000 inpatients in the UK and 500 000 in the USA down to only 27 000 in the UK currently and 72 000 in the USA by 1994 (Torrey, 1997). The introductions of antipsychotic drugs in 1952, quickly followed by antidepressants in 1957, have rightly been credited with much of this progress. However, changes were afoot earlier following the establishment of comprehensive welfare states in several countries.

Early progress was driven by mental health professionals, motivated by revelations of abuses, and a growing recognition of the risks of institutionalisation (Barton, 1959; Goffman, 1960). Chronic disabilities, long believed to be intrinsic to disorders and therefore indicating the need for ongoing hospital care, were now seen as reasons for discharge. Early discharges of minimally disabled patients generated great optimism but it quickly became clear that it would not be so straightforward with most patients. Many had no available families to support them and exhibited a range of enduring needs for care that no one individual professional could meet. These needs included those for medical, social, accommodation, occupational and general physical care. The traditional outpatient clinic was simply not up to this task. Community psychiatry and its trademark multidisciplinary team were born.

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Community care before 1980

It is helpful to divide community psychiatry's history into two distinct periods. The period to 1980, although increasingly scientific in its approach to diagnosis and treatment (e.g., the WHO's international clarification of schizophrenia's diagnosis and outcomes (World Health Organisation, 1973; Sartorius *et al.* 1977)) was a clinically driven, relatively athoretical and highly localised evolution. Clinicians, predominantly psychiatrists, tried things out and drew conclusions on what seemed to work. There was no structured system for disseminating or imposing 'models of practice'. This phase was poorly recorded with little systematic evaluation. Braun's overview of community outcome research in 1981 cited only eight studies (Braun *et al.* 1981). Judgements were made over time; if things seemed to work they endured and spread by word of mouth. Only later did a financial imperative accelerate the process in what Leona Bachrach referred to as 'an unholy alliance of therapeutic liberals and fiscal conservatives' (Bachrach, 1976).

The two most consistent and durable developments in this period were multidisciplinary teams with a variable degree of outreach and the move towards a geographical sectorisation of services. In the USA, Kennedy's 1963 legislation established Community Mental Health Centres. These centres were highly ambitious providing a comprehensive range of services but with little, if any, outreach. Ideological and staffing problems dogged the initiative from the start

and it failed to meet its goals, especially for the severely mentally ill (Talbott *et al.* 1987).

Europe adopted a more highly *sectorised* approach, pioneered in France and the UK, in which teams worked with all the inhabitants of geographically defined areas. Sectorisation facilitated effective collaboration with primary care, housing and social service agencies by establishing close personal working relationships. The emphasis was on availability and access and teams evolved a strikingly informal style of working that prioritised skill sharing and role blurring. Social workers and nurses were initially responsible for most of the outreach which has come to characterise these teams. By the 1980s over 80% of the UK population was served by a sector mental health team (Johnson & Thornicroft, 1993). In Germany, a federal review of care (the 1976 'Enquête') recommended a shift to community care, establishment of national standards and the study of several model programmes (Salize *et al.* 2007). This evolutionary period was crowned in 1978 by the introduction of 'Law 180' in Italy, which effectively abolished their mental hospitals (Mangen, 1985) establishing an ideologically confident community-based multidisciplinary team approach to psychiatry. Italy continues to challenge other systems with its reliance on a remarkably low number of acute beds, admirable continuity of care (Sytema *et al.* 1997) and the high morale of its staff (Fioritti *et al.* 1997).

1980 onwards: evidence-based mental health services

The publication of Stein and Test's landmark trial of Assertive Community treatment (ACT) marks the beginning of a period dominated by evidence-based care (Stein & Test, 1980). Service developments began to draw on published research evidence, and this brought a new internationalism. Research has broadly focused in three main areas. The first was in the reprovision for deinstitutionalisation – what was the fate of patients discharged from long-term care? The second was into a range of specialised alternative provisions – day hospitals, types of Community Mental Health Teams (CMHTs), etc. The third was evaluations of various psychosocial interventions to support community patients – social skills training, Cognitive Behaviour Therapy for psychosis, motivational interviewing, advance directives, etc.

Anglophone dominance

A review of community psychiatry's achievements in the era of evidence-based medicine is subject to a significant Anglophone distortion. Publications in languages other than English are read and cited disproportionately less frequently. The ease of writing and publishing in one's native language gives a clear advantage to the US and UK researchers although there are several European centres that produce sustained high-quality community psychiatry research. Obvious examples are the epidemiological studies from Manheim in Germany and the services, outcomes and cost-effectiveness studies from Verona in Italy. The Anglophone dominance in research, however, carries the risk of implying that their services were the only progressive ones. This is clearly not the case – there have been a series of impressive and creative developments in community psychiatry in Scandinavia, Italy, Spain, France, the Netherlands as well as in German-speaking countries. Each of these has its own tale to tell and towering, innovative figures to celebrate. Doing justice to the achievements in each health care culture (which is complicated by the differing order in which innovations were introduced) is beyond the scope of this review. The aim here is to draw out the major trends. These are genuinely international and credit is widely due, even if the studies cited to illustrate them are all too often from the UK and USA.

Reprovision

The fate of discharged long-stay patients was followed up in a number of early studies in the USA, Germany and in the UK. Outcomes depended to a great extent on local commitment to providing accommodation and support. Despite public concern, and often scathing criticism in the national press, reprovision seems to have been broadly a success in Europe, although less so in the USA (Bachrach, 1996). The Team for the Assessment of Psychiatric Services (TAPS) followed the resettlement of over 500 long-stay patients from Friern Barnet Hospital in London in a series of cohorts. They found that most preferred their new accommodation in hostels and few were readmitted, imprisoned or became vagrants (Trieman *et al.* 1999). Patients' own assessments of the move were overwhelmingly positive, with few wanting to return to hospital, although anticipated gains in quality of life and the expansion of social networks did not materialise. A similar picture emerged in a Berlin evaluation, but with some suggestion of improved satisfaction and quality of life (Priebe *et al.* 2002).

Notwithstanding this evidence deinstitutionalisation is indelibly linked in the public consciousness with mentally disordered street people. It forces community psychiatry to answer for complex ethical judgements between personal choice, dignity and care. Overall the assessment cannot be other than positive now most psychiatric patients spend their lives as

fellow citizens out in society with only intermittent, short readmissions. The long-term course of illnesses has not shown any noticeable deterioration and patients clearly prefer their new freedoms. There is some evidence of improved quality of life, reduction in social disability and some reduced stigma as a consequence of a greater visibility (Wolff *et al.* 1996).

Alternative provision

Perhaps the most vigorous and productive area of research within community psychiatry has been that into different forms of care. Deinstitutionalisation studies not only described overall outcomes but were also able to link these to different forms of care and accommodation. TAPS, for example, found that group homes for 8 to 12 patients generally worked better than either individual accommodation or larger group homes. Voluntary sector accommodation, although more variable, was less costly than that from statutory or health providers (Knapp *et al.* 1999). Most importantly, it was permanent homes, not rehabilitation or transitional placements that discharged patients valued. Community care, while reducing expenditure with less disabled patients could be more expensive for those with more severe problems (Knapp *et al.* 1999). It is not always the cheaper option.

Stein and Test's trial of ACT (Stein & Test, 1980) was enormously influential both because of the extent of the reduction of inpatient care but also because they carefully described their clinical model which allowed it to be replicated. It was followed by an unprecedented number of replications and trials (Mueser *et al.* 1998; Catty *et al.* 2002). Most of these used rate and duration of inpatient care or successful engagement as their primary outcomes. Over time the initial large advantages to ACT became diluted or absent. These differences in results were mainly due to better quality care in local control services and some minor variations in ACT application (Burns *et al.* 2007).

Adaptations of ACT have been tested for several specialist teams. Early Intervention Services for psychosis have been trialled (Craig *et al.* 2004; Petersen *et al.* 2005) as have crisis intervention teams (Johnson *et al.* 2005) with broadly similar conclusions**.** Careful comparisons between these studies, and in particular their outcomes, has led to a sharper understanding of the processes needed to support severely mentally ill patients in the community. These include regular outreach, predictable caseloads for case-managers, multidisciplinary team working, simultaneous attention to social care and the active involvement of psychiatrists (Wright *et al.* 2004; Burns *et al.* 2007). Evidence for the effectiveness of the routine sector CMHT has, paradoxically, been obtained primarily from studies where it has been used as the control condition. In these, it has persistently matched the outcomes of better funded and staffed specialist teams (Burns *et al.* 2007; Burns, 2009). Increased specialisation is a feature of all modern medicine and likely to characterise future developments in community psychiatry. Whether and when the benefits of a range of specialised teams outweighs the inevitable loss of continuity that they bring for long-term patients is an area of on-going debate with differing national conclusions.

Reducing reliance on inpatient care has also been tested using either diversion to day hospitals or actively shortening admissions. Acute day hospitals have proved themselves as viable alternatives to inpatient care for many patients (Creed *et al.* 1990) but have rarely been more widely adopted beyond research settings (Creed *et al.* 1991). Shortening admissions using immediate discharge planning has failed to confer advantages over the routine day-to-day effects of bed pressures (Hirsch *et al.* 1979).

Psychosocial interventions

An undoubted achievement of community psychiatry has been to re-energise interest in non-pharmacological treatments. Regular encounters with patients in non-institutional settings have led to a richer, more holistic understanding and a more equal relationship. This has highlighted the personal and interpersonal challenges they face in managing their illnesses. A range of psychosocial interventions to help with this have been introduced and evaluated. Psychoeducation for both patients (Colom *et al.* 2003) and their families (Dixon & Lehman, 1995), along with illness management training have become widespread practice.

Social skills training was an early hope which never fulfilled its promise (Pilling *et al.* 2002); Stein and Tests 1980 trial was originally called 'Training in Community Living'. However, social skills training provided a platform for further refinements such as 'Expressed Emotion' therapy (Leff *et al.* 1990), developed from observations linking relapses in psychosis with the family's psychological environment (Vaughn & Leff, 1976). It comprises both psychoeducation and a highly refined skills training to reduce family tensions, and has been demonstrated to reduce relapse rates (Leff *et al.* 1982). The use of Cognitive Behaviour Therapy to reduce persistent hallucinations and delusions in schizophrenia has attracted widespread interest. Its effectiveness remains controversial (Jauhar *et al.* 2014) and it is undoubtedly difficult to implement in routine settings, but is recommended in many guidelines and supported by some impressive studies (Turkington *et al.* 2002, 2006). A recent trial (Howes, 2014) has gone so far as to speculate whether

https://doi.org/10.1017/S2045796014000560 Published online by Cambridge University Press

it could be an alternative to maintenance antipsychotics for a significant minority of patients.

In much of this work improved outcomes from psychosocial interventions appears to be mediated through improved adherence to maintenance antipsychotic regimes. Procedures directly aimed at improving this adherence have also been experimented with and these range from motivational interviewing (O'Donnell *et al.* 2003) to directly paying patients to take their medication, the so-called 'contingency management' (Priebe *et al.* 2013*b*). Improving adherence was an explicit aim of ACT and the last 30 years has seen a much more active and focused approach to medication management in all community services.

The psychosocial interventions considered above aim to improve the patient's wellbeing by reducing psychopathology in one way or another. Some community psychiatry interventions aim to short-circuit this approach and directly address the consequences of this psychopathology such as unemployment or homelessness. The severely mentally ill have the highest rates of unemployment of any disability group. Vocational rehabilitation based on careful assessment and structured programmes to address deficits and disabilities were a prominent feature of early deinstitutionalisation strategies. However, they achieved only low rates of eventual employment. Individual Placement and Support (IPS) abandons such programmes and directly matches unemployed patients with jobs. With a steadily expanding stream of Randomised Controlled Trials (RCTs) demonstrating its effectiveness (Bond *et al.* 2008) IPS has been adopted as national and regional policy in several locations. Similarly the 'Housing First' approach to mentally ill homeless individuals provides accommodation independent of engagement in treatment programmes. It reports not only an enduring improved housing stability but also improvements in other social and some clinical outcomes (Greenwood *et al.* 2005).

The shape and 'experience' of community psychiatry services

In much of the planning for community psychiatry in the 1970s and 1980s the health care model envisaged was one of acute inpatient units in general hospitals. These would be supported by extensive day hospital provision, plus some specialised rehabilitation units and forensic units for mentally disordered offenders. Primary care was expected to manage less severely ill patients. Sheltered accommodation and social support were anticipated to move from health to social care. Most of this has come to pass although the extent of provision has varied and in the current period of austerity social support has sometimes been scaled back. With dramatic reductions in bed numbers the level of disturbance in public acute mental health inpatient units is now very high and the pressure for early, even premature, discharge is fierce.

Two unanticipated and widespread developments have marked current community psychiatry. The first is an increasing fragmentation of care and erosion of continuity as more and more specialised teams have been established. An increasing specialisation of services is an inevitable development as treatments become more sophisticated and better defined. Specialised teams comprise both those relating to different phases in the natural history of mental illnesses (early intervention, crisis, ACT, etc.) plus disorder-specific services which have become more common (bipolar disorders, ADHD, Autism teams, etc.). A lively debate exists about whether specialised teams should replace 'outmoded' generic teams with a patchwork of targeted alternatives or serve as specialist resources to them (Burns, 2009). While this goes on much of Europe has been successfully consolidating continuity of care across the inpatient and community boundary and this is strongly recommended in a recent European Psychiatric Association service guidelines (Gaebel *et al.* 2012). Such continuity has characterised services in Italy and the UK for several decades although paradoxically currently being dismantled in parts of the UK.

The second unexpected development has been the striking increase in coercion and compulsion. Across parts of Europe and the USA the emphasis on risk assessment has increased enormously (Mullen, 2000; Alec *et al.* 2012). Compulsory inpatient treatment, which was expected to shrink with improved community care, has increased steadily across most countries where reliable statistics are kept. This is not just a case of the same patients experiencing more, shorter compulsory admissions but also of a greater proportion of patients overall being subject to compulsion (Salize & Dressing, 2004). While there is evidence that this may in part be a response to inadequate bed provision (Keown *et al.* 2011) this cannot explain the simultaneous rise in countries with very different capacities. Indeed there is some suggestion from the Netherlands and Austria that attempts at liberalising mental health legislation to protect the rights of capacitous patients have led to increased rather than decreased levels of coercion (Zinkler & Priebe, 2002).

The growth in coercion has not been limited to the rise in compulsory admissions. As well as a marked rise in forensic psychiatry beds across Europe in this period (Priebe *et al.* 2005) we have witnessed an entirely new phenomenon – the extension of compulsion into the care of patients outside hospital. There are now over 70 jurisdictions, (Rugkåsa & Dawson, 2013)

https://doi.org/10.1017/S2045796014000560 Published online by Cambridge University Press

which have mechanisms to legally impose supervision and treatment for extended periods (months and even years) outside hospitals. These regimes are very similar in practice and target similar patients (middle-aged psychosis patients, most often suffering from schizophrenia, who are isolated, lack insight and at risk for non-adherence, self-neglect and rapid relapse). However, their rate of use varies wildly from hardly at all in many US states to one per thousand adults in Victoria Australia. This growth in community coercion has often been driven by high profile tragedies (Sjöström *et al.* 2011) and currently appears relentless despite the absence of any convincing evidence for its effectiveness (Maughan *et al.* 2013).

Advocacy, recovery and the user movement

These recent developments of increasing coercion and an emphasis on the technological aspects of care rather than a holistic relational approach have generated an increased resistance from many stakeholders. They have been paralleled with a growth in advocacy, an emphasis on personal recovery as the appropriate goals for care and an increasingly vocal user movement. The growth in advocacy and an often strident tone in the user (or more provocatively 'survivor') movement is driven by a perceived need to protect human rights and often by a broad opposition to compulsory care. Sadly psychiatry continues to provide good reasons for mistrust although the specific practices that attract opprobrium (restraints, caged beds, seclusion and forced medication) vary markedly from country to country, as does the strength of the opposition. As with the user movement advocacy focuses on campaigning for broad principles and human rights although it has generated some quite specific practices such as advance directives (Thornicroft *et al.* 2013) to embody these principles. It is challenged by having to confront very differing scenarios in different countries – ranging from overzealous treatment to the absence of any reasonable access to treatment. The recovery movement (Slade, 2009) is more firmly anchored in the individual patient's journey rather than on national systems. It emphasises the central importance of choice and personal satisfaction balanced against the professionals' desire to 'cure'.

Discussion and conclusions

The asylum movement took 150 years to reach its zenith in the 1950s. During that time it encapsulated the high moral purpose of the Victorian era and was often the greatest single public expenditure for many authorities. Overwhelmed by demand and underfunded it fell into disrepute, marked by an impersonal and mechanical approach and marred by regular scandals and abuses. There were good reasons to rethink it in the after war period and the conditions were right. The establishment of various forms of welfare state made deinstitutionalisation possible and a changed, more inclusive and less deferential, world view made it desirable. It reflected the tenor of the times. Doors were being opened and fledgling community services established before the introduction of antipsychotics provided the momentum.

It is, however, important to recognise that this is a very localised 'revolution'. In most of the developing world there is no community psychiatry, often there is no psychiatry at all or just custodial institutions. Most of what is described and researched is either in North America or Europe. Even in Europe there are variations between north and south and between east and west. In the east, particularly the former soviet bloc countries, community psychiatry is vestigial while in the west it is highly developed though taking various forms. The highest spend and most extensive and complex community services are common in the north of Europe and social care more often left to the family in the south.

Community Psychiatry, like the asylums that preceded it, is an idea of its time. It is founded on a series of social assumptions and expectations, some articulated, many not. For some decades reducing beds, re-engaging families and providing continuing social and medical support within relatively stable communities seemed enough. It was not, for instance, necessary to make calculations about 'how many beds' as it was simply obvious that there were too many. In several European countries, even enthusiasts now question whether there are too few (Keown *et al.* 2011). Community Psychiatry now faces the reality of a rapidly changing and unpredictable landscape.

Professor Norman Sartorius having surveyed these changes for the WHO suggests that globalisation and the demographic shift make sustaining any 'golden age' of community psychiatry unrealistic. The speed of urbanisation and extent of migration undermine clinical strategies that rely heavily on local networks and social capital. Families are dispersed and no longer able to support ill members – particularly so as women have taken their place in the workforce. Society's willingness to transfer wealth or devote energy to support vulnerable individuals is no longer certain. The burgeoning middle classes in several rapidly expanding economies actively insulate themselves from any contact with, or obligation to, the poor. An unthinking application of Community Psychiatry principles and practice across widely different contexts carries the greatest risks. We remain in thrall to universality and internationalism when our experience, and

https://doi.org/10.1017/S2045796014000560 Published online by Cambridge University Press

much of our research, indicates the need for Community Psychiatry to take account of local conditions. What works in Trieste may not work in New York, what works in New York may not work in Trieste. There is no place for dogmatism.

Community Psychiatry has undoubtedly facilitated the closure of large asylums and few mourn their passing. It has provided a range of practices to support patients who would previously have spent much of their lives in such places. That their current lives are broadly happier, more dignified and less stigmatised is hard to contest. However, for a small minority, community care exposes their suffering and personal failure in the most painful manner. This poses difficult ethical questions about care and protection, and independence and autonomy for both our own professions and society more generally.

If there is no going back to the large asylums is the term 'Community Psychiatry' still relevant? Is not all psychiatry now community psychiatry? Given the enduring attraction of biomedical and institutional psychiatry it might be premature to give it up. However, it can no longer be simply a shorthand for multidisciplinary CMHTs and outreach. Its role is changing. It serves to focus us on the need to listen to patients, respond to context and reaffirm that psychiatry is a wider social endeavour that is located firmly in relationships for both its diagnoses and its treatments (Priebe *et al*. 2013*a*).

Financial support

This paper received no specific grant from any funding agency, commercial or not-for-profit sectors

Conflict of interest

The author declares that he has no conflict of interest.

References

Alec B, Renée LB, Michael N, Marvin S (2012). Psychiatric violence risk assessment. *American Journal of Psychiatry* **169**, 340.

Bachrach LL (1976). *Deinstitutionalization: An Analytical Review and Sociological Perspective*. US Department of Health, Education and Welfare, NIMH: Rockville, USA.

Bachrach LL (1996). Lessons from America: semantics and services for mentally ill homeless individuals. In *Homelessness and Mental Health* (ed. D Bhugra), 230–243. Cambridge University Press: Cambridge.

Barton R (1959). *Institutional Neurosis*. John Wright: Bristol.

Bond GR, Drake RE, Becker DR (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal* **31**, 280–290.

Braun P, Kochansky G, Shapiro R, Greenberg S, Gudeman JE, Johnson S, Shore MF (1981). Overview: deinstitutionalization of psychiatric patients, a critical review of outcome studies. *American Journal of Psychiatry* **138**, 736–749.

Burns T (2009). End of the road for treatment-as-usual studies? *British Journal of Psychiatry* **195**, 5–6.

Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *British Medical Journal* **335**, 336.

Catty J, Burns T, Knapp M, Watt H, Wright C, Henderson J, Healey A (2002). Home treatment for mental health problems: a systematic review. *Psychological Medicine* **32**, 383–401.

Colom F, Vieta E, Martinez-Aran A, Reinares M, Goikolea JM, Benabarre A, Torrent C, Comes M, Corbella B, Parramon G (2003). A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. *Archives of General Psychiatry* **60**, 402–407.

Craig TK, Garety P, Power P, Rahaman N, Colbert S, Fornells-Ambrojo M, Dunn G (2004). The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *British Medical Journal* **329**, 1067–1070.

Creed F, Black D, Anthony P, Osborn M, Thomas P, Tomenson B (1990). Randomised controlled trial of day patient versus inpatient psychiatric treatment. *British Medical Journal* **300**, 1033–1037.

Creed F, Black D, Anthony P, Osborn M, Thomas P, Franks Polley R, Lancashire S, Saleem P, Tomenson B (1991). Randomised controlled trial of day and in-patient psychiatric treatment. 2: comparison of two hospitals. *British Journal of Psychiatry* **158**, 183–189.

Dixon LB, Lehman AF (1995). Family interventions for schizophrenia. *Schizophrenia Bulletin* **21**, 631–643.

Fioritti A, Lo RL, Melega V (1997). Reform said or done? The case of Emilia–Romagna within the Italian psychiatric context. *American Journal of Psychiatry* **154**, 94–98.

Gaebel W, Becker T, Janssen B, Munk-Jorgensen P, Musalek M, Rössler W, Sommerlad K, Tansella M, Thornicroft G, Zielasek J (2012). EPA guidance on the quality of mental health services. *European Psychiatry* **27**, 87–113.

Goffman I (1960). *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*. Penguin Books: Harmondsworth, Middlesex.

Greenwood RM, Schaefer-Mcdaniel NJ, Winkel G, Tsemberis SJ (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology* **36**, 223–238.

Hirsch SR, Platt S, Knights A, Weyman A (1979). Shortening hospital stay for psychiatric care: effect on patients and their families. *British Medical Journal* **1**, 442–446.

Howes O (2014). Cognitive therapy: at last an alternative to antipsychotics? *Lancet* **383**, 1364–1366.

Jauhar S, Mckenna P, Radua J, Fung E, Salvador R, Laws K (2014). Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with

examination of potential bias. *British Journal of Psychiatry* **204**, 20–29.

Johnson S, Thornicroft G (1993). The sectorisation of psychiatric services in England and Wales. *Social Psychiatry and Psychiatric Epidemiology* **28**, 45–47.

Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, Mckenzie N, White IR, Thompson M, Bebbington P (2005). Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *British Medical Journal* **331**, 599.

Keown P, Weich S, Bhui KS, Scott J (2011). Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988–2008: ecological study. *British Medical Journal* **343**, 196–204.

Knapp M, Hallam A, Beecham J, Baines B (1999). Private, voluntary or public? Comparative cost-effectiveness in community mental health care. *Policy and Politics* **27**, 25–41.

Leff J, Kuipers L, Berkowitz R, Eberlein-Vries R, Sturgeon D (1982). A controlled trial of social intervention in the families of schizophrenic patients. *British Journal of Psychiatry* **141**, 121–134.

Leff J, Berkowitz R, Shavit N, Strachan A, Glass I, Vaughn C (1990). A trial of family therapy versus a relatives' group for schizophrenia. Two-year follow-up. *British Journal of Psychiatry* **157**, 571–577.

Mangen SP (1985). Psychiatric policies: development and constraints. In *Mental Health Care in the European Community* (ed. SP Mangen), 1–33. Croom Helm: London.

Maughan D, Molodynski A, Rugkåsa J, Burns T (2013). A systematic review of the effect of community treatment orders on service use. *Social Psychiatry and Psychiatric Epidemiology*, 1–13. DOI: 10.1007/s00127-013-0781-0.

Mueser KT, Bond GR, Drake RE, Resnick SG (1998). Models of community care for severe mental illness: a review of research on case management. *Schizophrenia Bulletin* **24**, 37–74.

Mullen PE (2000). Forensic mental health. *British Journal of Psychiatry* **176**, 307–311.

O'Donnell C, Donohoe G, Sharkey L, Owens N, Migone M, Harries R, Kinsella A, Larkin EO (2003). Compliance therapy: a randomised controlled trial in schizophrenia. *British Medical Journal* **327**, 834.

Petersen L, Jeppesen P, Thorup A, Abel MB, Ohlenschlaeger J, Christensen TO, Krarup G, Jorgensen P, Nordentoft M (2005). A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness. *British Medical Journal* **331**, 602.

Pilling S, Bebbington P, Kuipers E, Garety P, Geddes J, Martindale B, Orbach G, Morgan C (2002). Psychological treatments in schizophrenia. II. Meta-analyses of randomized controlled trials of social skills training and cognitive remediation. *Psychological Medicine* **32**, 783–791.

Priebe S, Hoffmann K, Isermann M, Kaiser W (2002). Do long-term hospitalised patients benefit from discharge into the community? *Social Psychiatry and Psychiatric Epidemiology* **37**, 387–392.

Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian R, Torres-Gonzales F, Turner T, Wiersma D (2005). Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. *British Medical Journal* **330**, 123–126.

Priebe S, Burns T, Craig TK (2013*a*). The future of academic psychiatry may be social. *British Journal of Psychiatry* **202**, 319–320.

Priebe S, Yeeles K, Bremner S, Lauber C, Eldridge S, Ashby D, David AS, O'CONNELL N, Forrest A, Burns T (2013*b*). Effectiveness of financial incentives to improve adherence to maintenance treatment with antipsychotics: cluster randomised controlled trial. *British Medical Journal* **347**, 11–21.

Rugkåsa J, Dawson J (2013). Community treatment orders: current evidence and the implications. *British Journal of Psychiatry* **203**, 406–408.

Salize HJ, Dressing H (2004). Epidemiology of involuntary placement of mentally ill people across the European Union. *British Journal of Psychiatry* **184**, 163–168.

Salize HJ, Rössler W, Becker T (2007). Mental health care in Germany. *European Archives of Psychiatry and Clinical Neuroscience* **257**, 92–103.

Sartorius N, Jablensky A, Shapiro R (1977). Two-year follow-up of the patients included in the WHO International Pilot Study of Schizophrenia. *Psychological Medicine* **7**, 529–541.

Sjöström S, Zetterberg L, Markström U (2011). Why community compulsion became the solution – reforming mental health law in Sweden. *International Journal of Law and Psychiatry* **34**, 419–428.

Slade M (2009). *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals (Values-Based Practice)*. Cambridge University Press: Cambridge, UK.

Stein LI, Test MA (1980). Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry* **37**, 392–397.

Sytema S, Micciolo R, Tansella M (1997). Continuity of care for patients with schizophrenia and related disorders: a comparative South-Verona and Groningen case-register study. *Psychological Medicine* **27**, 1355–1362.

Talbott JA, Clark Jr. GH, Sharfstein SS, Klein J (1987). Issues in developing standards governing psychiatric practice in community mental health centers. *Hospital and Community Psychiatry* **38**, 1198–1202.

Thornicroft G, Farrelly S, Szmukler G, Birchwood M, Waheed W, Flach C, Barrett B, Byford S, Henderson C, Sutherby K, Lester H, Rose D, Dunn G, Leese M, Marshall M (2013). Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. *Lancet* **381**, 1634–1641.

Torrey EF (1997). *Out of the Shadows: Confronting America's Mental Ill-ness Crisis*. John Wiley: New York.

Trieman N, Leff J, Glover G (1999). Outcome of long stay psychiatric patients resettled in the community: prospective cohort study. *British Medical Journal* **319**, 13–16.

Turkington D, Kingdon D, Turner T (2002). Effectiveness of a brief cognitive-behavioural therapy intervention in the treatment of schizophrenia. *British Journal of Psychiatry* **180**, 523–527.

Turkington D, Kingdon D, Rathod S, Hammond K, Pelton J, Mehta R (2006). Outcomes of an effectiveness trial of

cognitive-behavioural intervention by mental health nurses in schizophrenia. *British Journal of Psychiatry* **189**, 36–40.

Vaughn CE, Leff JP (1976). The influence of family and social factors on the course of psychiatric illness. *British Journal of Psychiatry* **129**, 125–137.

Wolff G, Pathare S, Craig T, Leff J (1996). Community knowledge of mental illness and reaction to mentally ill people. *British Journal of Psychiatry* **168**, 191–198.

World Health Organisation (1973). Report of the international pilot study of schizophrenia.

Wright C, Catty J, Watt H, Burns T (2004). A systematic review of home treatment services. Classification and sustainability. *Social Psychiatry and Psychiatric Epidemiology* **39**, 789–796.

Zinkler M, Priebe S (2002). Detention of the mentally ill in Europe – a review. *Acta Psychiatrica Scandinavica* **106**, 3–8.