Mental Health

BACKGROUND

The social work profession has provided leadership in the provision of mental health services. Social workers develop and implement multilevel interventions that target the individual, family, community, and larger psychosocial systems.

Psychiatric conditions are common in the United States, with a lifetime prevalence rate of 46.4 percent (Kessler, Berglund, et al., 2005) and a 12-month prevalence rate of 26.2 percent for any diagnosis (Kessler, Chiu, Demler, & Walters, 2005). The costs pertaining to mental health conditions are staggering and are illustrated through statistics, role disability, financial burden of disease, and the face of human suffering and disability (Heller & Gitterman, 2010). Social workers are the largest group of clinically trained mental health providers in the United States (Newhill & Korr, 2004; Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). By the nature of the profession's dual focus on enhancing the well-being of individuals and working toward social and economic justice, social workers are well-positioned to intervene, on both individual and systemic levels, with people affected by the challenges of mental health conditions. Recent legislation (the Patient Protection and Affordable Care Act of 2010 [P.L. 111-148]; the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 [P.L. 110-343]) has promised significant changes in access to both insurance and services to a broader range of the American population, but current political and economic forces make the eventual realization of these efforts uncertain.

The history of treatment for mental illness in the United States is marked by shifting assumptions about the etiology of mental illness, from theories of moral depravity, maternal failures, brain disease, and social construction to philosophies, levels of care, and legislation regarding access to care (Mechanic, 2008).

Legislative and policy decisions that demonstrate the country's developing beliefs about definitions of mental illness, the settings in which care should occur, and the degree to which society should make available both access and funding for the provision of services to people with mental illness include the following:

- the National Mental Health Act of 1946 (P.L. 79-487), which emerged from the controversial screenings for recruits for military service and resulted in the establishment of National Institute of Mental Health.
- the Mental Health Study Act of 1955 (P.L. 84-182), which led to the Joint Commission on Mental Illness and Health's report *Action for Mental Health* in 1961.
- the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) and its amendments (1965, 1975), which authorized funding for professional training for community mental health centers for outpatient, inpatient and partial hospitalization, emergency care, and education for community caretakers.
- the Education for All Handicapped Children Act of 1975 (P.L. 94-142).
- the Mental Health Systems Act of 1980, providing improved services to people with mental illness.
the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), which repealed the Mental Health Services Act and withdrew the federal government’s involvement in service provision by the Alcohol, Drug Abuse, and Mental Health Administration’s consolidation of funding into single block grants to each state.

- the State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660), with its focus on people with severe mental illness, particularly the homeless.

- the 1987 Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), which aimed to see that people were treated in the least restrictive setting.


- the Americans with Disabilities Act of 1990 (P.L. 101-336), covering people with both physical and psychiatric conditions.

- the development of SAMHSA in 1992, which made available community mental health services block grants that included a focus on children and adolescents with mental health issues and, subsequently, specialized programs targeting women, older adults, and various other age groups and ethnic populations.

- the Mental Health Parity Act of 1996 (P.L. 104-204), which prohibited disparate annual or lifetime limits on coverage for mental health and general health care.

- In 1997 the insurance industry’s regulatory body, the National Committee on Quality Assurance (NCQA), began to require compliance with postpsychiatric discharge follow-up standards.

- the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343), which extends parity to health and mental health diagnoses in the International Classification of Diseases, Ninth Revision, Clinical Modification.

- the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), which aims, among other things, to make health insurance available to more individuals and expands Medicaid’s eligibility requirements for mental health treatment.

One of the explicit objectives of managed care was seamless patient transition between levels of care, including institutional, residential, hospital, partial hospital, intensive outpatient, and outpatient. Although such a seamless transition is a natural conceptual extension of the “one-stop-shopping” afforded by health maintenance organizations, especially those sponsored by hospitals, vertical integration proved to be challenging. In response, 1997 saw the industry’s primary regulatory body, the NCQA, begin to require compliance with postpsychiatric discharge follow-up standards. The data do show improvement; however, the outcomes still fall short of the goals of seamlessness and vertical integration. Such is the case in community mental health care as well.

Linkages across types of systems are even more fractured. Although there are higher rates of mental illness in incarcerated populations than in the general population (Rouse, 1995), there continue to be low rates of follow-up for mental health services after release from correctional facilities.

Compared with involuntary inpatient hospitalization, compulsory outpatient treatment is a relatively new phenomenon. An individual must be assessed to be unlikely to live safely without supervision. In addition, he or she must have a history of treatment noncompliance related to psychiatric hospitalization or incarceration or have committed serious acts—or threats—of violence to self or others. Forty-four states have enacted legislation related to involuntary treatment over the last decade.

There have been three empirical studies of the effectiveness of Kendra’s Law, a 1999 New York state piece of legislation addressing court-ordered outpatient treatment. The conclusions of the New York State Office of Mental Health’s 2005 study were that Kendra’s Law resulted in dramatically lower rates of homelessness, psychiatric hospitalization, and arrest and incarceration. Costs varied directly with these reductions. Moreover, rates of substance abuse, victimization, and harm to self, other, or property all plummeted, whereas illness-related psychosocial functioning improved.
ISSUE STATEMENT

Mental illness is a common health problem in the United States affecting millions of people each year in all age groups. More than 26 percent of the nation's adult population experiences mental illness, and 6 percent of this population experiences a severe mental illness (see http://www.nimh.nih.gov/statistics/index.shtml). However, because many people with mental illness never receive treatment, it is difficult to determine the actual prevalence of mental illness. With the stigma of mental illness decreasing, more Americans are seeking mental health services. From 1996 to 2006, the number of Americans paying for mental health services increased 87 percent (Agency for Healthcare Research Quality, n.d.). Yet there continue to be key barriers to treatment, including cultural disparities, access to care, stigma, and reimbursement challenges (President's New Freedom Commission on Mental Health, 2003).

The burden of mental illness is concentrated on those who experience a serious mental illness resulting in functional impairment that interferes or limits one or more major life activities. Comorbid conditions complicate mental illness, and populations with comorbid conditions usually seek help, whereas others with single disorders may not. In the United States, depression leads individual diseases and disorders that contribute to total number of years lost to illness, disability, or premature death. Suicide has increased over the past 10 years and in 2007 was the fourth leading cause of death in the United States for people ages 18 to 65 years (Centers for Disease Control and Prevention, 2007).

Over 20 percent of children and adolescents in the United States have experienced a severe mental illness. Attention-deficit hyperactivity disorder and mood and conduct disorders are most common among youths ages eight to 15, and gender does not appear to be a statistical factor (see http://www.nimh.nih.gov/statistics/index.shtml).

Adolescents and adults in the mental health system often have histories of early trauma, abuse, and neglect. Inadequate prenatal care, lack of appropriate nutrition, difficult birth, and high levels of stress in the mother affect the developing fetus, creating neurochemical vulnerabilities within the child as it develops through infancy and into adulthood (Purvis, Cross, & Sunshine, 2007).

In infancy, a child's beliefs about self and others are taking form through the attachment process with his or her primary caregivers. Impaired attachment in childhood can, and often does, affect the ability of the individual to develop healthy relationships in adulthood, leading to mental health concerns, damaged interpersonal relationships, and an impaired ability to care for and value self and others (Schechter & Willheim, 2009). The availability and use of professional support for parents in preparing for the birth of a child, and through the early years of the child's development, can have a significant positive impact on the outcomes for the child and the family (Purvis et al., 2007).

Mental health is the fourth highest ranking rural health concern (Gamm, Stone, & Pittman, 2003). Yet, in many rural communities, mental health services are not available (Gustafson, Preston, & Hudson, 2009) due to chronic shortages of clinical social workers and mental health clinicians (Calk, Loux, Shaw, & Hartley, 2010; Gustafson et al., 2009). Data show that residents of the most rural areas receive less mental health treatment than people residing in metropolitan areas (Hauerstein et al., 2007). Furthermore, there is evidence of higher suicide rates, a standard indicator of mental illness, in rural areas (D'Mello, 2010). Higher suicide rates correspond to regions in the United States that have the least number of mental health providers (D'Mello, 2010). Despite the need for mental health services in rural communities, availability and accessibility are major barriers that prevent rural Americans from receiving the care they need (Gustafson et al., 2009). Military personnel and veterans encounter stress through being at war, multiple and extended deployments, and separation from loved ones. These factors contribute to the development of mental health issues such as posttraumatic stress disorder, depression, substance use, and anxiety. Mental health problems experienced by this population have an effect on military personnel's families while they are serving as well as when they return home.
A related development is the growing impact of the recovery movement on the ways in which mental health care is conceptualized and delivered. "The concept of recovery is consistent with the values of social work" (Garrison, Ackerson, & Forrest, 2010) and is widely embraced by the social work profession. A pioneer in recovery, William Anthony (1993), defined *recovery* as

> a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Social work has been at the forefront of the development and implementation of this model. The recovery movement/model allows for and supports the integration of consumers in their own treatment, allowing them to guide their own treatment as they move toward improved health and recovery.

**POLICY STATEMENT**

NASW maintains its commitment to enhancing the well-being of people living with mental health conditions and working toward increased access to appropriate services and interventions. NASW is committed to improving mental health services and advocates for legislative action to improve the quality of care, access, reimbursement, research, and education in mental health.

To further the advances that have been made in the prevention, diagnosis, assessment, and treatment of mental illness, NASW supports the following:

**Prevention and Education**

- Prevention and outreach programs—including education, consultation, and early intervention—should be fully funded and provided to the public to

- promote an understanding of the effects of prenatal and early childhood issues on the subsequent development of mental illness

- destigmatize and maximize early identification and treatment of mental illness

- promote individual and family wellness programming

- foster resilience in people experiencing mental illness and in those who care for them.

**Access to Services**

- Fully integrated, comprehensive services should be made available for all who experience mental illness, particularly those with chronic and severe illness.

- Culturally responsive interventions in the consumers’ native languages should be included in the provision of effective mental health care.

- Family members and significant others should be included in the process of assessment, treatment planning and intervention and should have access to supportive services to help them address the problems posed by the mental illness of a loved one.

- Mental health parity is important and should be defined consistently among health plans.

- The process of, and opportunities for, appealing adverse treatment decisions should be enhanced.

- A broad range of housing and vocational services should be available to people who have severe mental illness so as to strengthen their independent living skills, support their efforts to build stable and supportive relationships, and improve their quality of life.

- Productive work should not result in sanctions affecting social insurance, public assistance, or access to other programs.

**Intervention and Treatment**

- Behavioral health care plans should rely on the best judgment of mental health clinicians
when making service determinations, including the type, level, and duration of services.

- Consumers should be given choices of service options that meet their needs, with services provided in the most therapeutic and least restrictive environments possible.

- Evidence-based practice paired with clinical judgment should be considered in making clinical decisions.

- Involuntary hospitalization or outpatient treatment should balance consumers’ rights to self-determination with the safety of family members and the community.

- Comorbid substance use disorders should not be given undue weight in the assessment of functional capacity or in eligibility determination for social insurance, public assistance, and social services.

- The mental health challenges faced by veterans and their families should be addressed in a comprehensive and readily accessible manner. Education and early intervention for returning service personnel and their families should be provided as an integral part of that care.

- Incarcerated individuals should be provided full access to mental health services, including screening, assessment, medication, counseling, and discharge planning.

- To strengthen best practices, social workers should pursue research funding to test mental health treatment methodologies and outcomes. Underserved populations should be included in the design of research projects whenever possible.

REFERENCES


**NASW Members with Primary Responsibility for Revision of This Policy**

**First Draft Revision:**

Daniel M. Potter (IL)

**Policy Panelists:**

Nina Heller (CT)
Charles Greco (NYS)
Robin Lennon Dearing (TN)
Mary Garrison (IL)
Susan Eldredge (TX)
Renée Rivera (CO)

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