chapter

2 Current Mental Health Care Systems

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Objectives

Upon completion of this chapter, the student will be able to:

1. Describe the current mental health care system in Canada, Norway, the United Kingdom, Australia, and the United States.
2. State the major difference between inpatient and outpatient psychiatric care.
3. Explain the community support systems model of care.
4. List four settings for community mental health care delivery.
5. Identify five components of the case management method of mental health care.
6. Discuss the roles and purpose of the multidisciplinary mental health care team.
7. Name four high-risk populations served by community mental health centers.
8. List five community-based mental health services for people with HIV/AIDS.

Key Terms

advocacy (ĂD-və-kə-sē) (p. 14)
case management (KĀS MĂN-ăge-MĬNT) (p. 14)
community (kă-MŪN-ĭ-tē) **mental health centers** (p. 12)
community support (kă-MŪN-ĭ-tē să-PŌRT) **systems (CSS) model** (p. 12)
consultation (KŎN-sŭl-TĀ-shən) (p. 14)
crisis intervention (KRĪ-sĭs ĬN-tər-vən-shən) (p. 15)
diagnosis-related (DĪ-əg-NŌ-sĭs) **groups (DRGs)** (p. 18)
homelessness (HŌM-lĕs-nĕs) (p. 18)
inpatient psychiatric (ĬN-PĀ-shənt sī-kē-ăt-rĭk) **care** (p. 11)
multidisciplinary (MŬL-tĭ-dĭ-sĭ-plə-nă-rē) **mental health care teams** (p. 16)
outpatient (ŎWT-PĀ-shənt) **mental health care** (p. 11)
psychosocial rehabilitation (sī-kō-SŌ-shəl RĒ-hă-bĭl-ə-TĀ-shən) (p. 14)
recidivism (rē-SĬD-ĭ-vĭz-əm) (p. 12)
resource linkage (RĒ-sōrs LĒNK-əg) (p. 14)

The delivery of a population's health care varies with the culture. Because cultures, values, and beliefs differ, international comparisons of health care systems are difficult to make. The more developed nations have complex health care systems, but almost half of all countries in the world "have no explicit mental health policy and nearly a third have no program for coping with the rising tide of brain-related disabilities" (ASHA, 2011).

MENTAL HEALTH CARE IN CANADA

By the late 1960s, Canada adopted a **government-administered health insurance plan.** Today a "single-payer arrangement" is used in the Canadian health care system, which is based on five principles: universality, portability, accessibility, comprehensiveness, and public administration. Each guiding principle is explained in Box 2-1.

Each province or territory organizes, administers, and monitors the health care delivery system of its citizens. Benefits may vary, but all Canadian citizens are eligible for diagnostic, emergency, outpatient, medical, hospital, convalescent, and mental health services. Medications for people over age 65 years are also provided. The agency responsible for the health of Canadians is the Department of National Health and Welfare.

Canada's health care system is divided into curative and preventive operations with the major focus on treatment. "Private psychotherapy, community mental health, other day programs, and hospital psychiatric services" (Kirkpatrick, 1999) are available to every Canadian based on need.

MENTAL HEALTH CARE IN NORWAY

Like other European countries, Norway has adopted a **national insurance system** that provides access to health care for everyone living in Norway. Employees contribute a percentage of their wages and pay out-of-pocket fees for health care until a "payment ceiling" (about $175) is reached. Thereafter, all services are covered except adult dental care.

Hospitals and specialized medical services are managed by Norway's 19 counties, whereas primary

- A book written by Clifford Beers about his experience as a mental patient set the mental hygiene movement of the early 1900s into motion.
- By the 1920s, Sigmund Freud's psychoanalytic theories became a popular method for treating emotional problems.
- The First and Second World Wars pointed out the need for comprehensive mental health care.
- With the introduction of psychotherapeutic drug treatment, many psychiatric institutions closed.
- Community mental health centers were built during the 1970s, but a change in political climate left the project uncompleted and countless mentally ill people without treatment.
- Today, many legislative changes again challenge us to develop comprehensive, cost-efficient care for society's mentally ill members.

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Review Questions for the NCLEX® Examination

1. During the Dark Ages, demonic exorcisms were performed as a result of the belief that mental illness was punishment for sins, the result of witchcraft, or caused by:
   1. Imbalance of fundamental elements
   2. Possession by the devil
   3. Rational soul controlling the irrational soul
   4. Chemical imbalances within the body
2. In the early 1800s, Dr. Benjamin Rush wrote the first psychiatric text, *Diseases of the Mind,* in which he advocated which conditions for the mentally ill? **Select all that apply.**
   1. Kindness
   2. Clean conditions
   3. Good air, lighting, and food
   4. Proper administration of psychotherapeutic drugs
3. If a person's behaviors interfere with daily activities, impair her judgment, or alter her perception of reality, this person is considered to be:
   1. Confused
   2. Disoriented
   3. Mentally healthy
   4. Mentally ill
4. In the early 1900s, the neurophysiologist Sigmund Freud is credited with introducing which concept?
   1. Psychoanalysis
   2. Insanity
   3. Lunacy
   4. Mental illness
5. Based on the concept of the health-illness continuum, which actions can a mentally healthy individual do? **Select all that apply.**
   1. Avoid stressors during activities of daily living.
   2. Respond to stress with effective behaviors.
   3. Develop effective coping mechanisms.
   4. Set realistic goals for themselves.

Box 2-1 Principles of the Canadian Health Act

1. *Universality*. Everyone in the nation is covered.
2. *Portability*. People can move and still retain their health coverage.
3. *Accessibility*. Everyone has access to the system's health care providers.
4. *Comprehensiveness*. Provincial plans cover all medically necessary treatment.
5. *Public administration*. The system is publicly run and publicly accountable.

From Edelman CL, Mandle CL: *Health promotion throughout the lifespan*, ed 5, St Louis, 2002, Mosby.

health care services are organized on the municipal level. Mental health care is available to all citizens of Norway.

MENTAL HEALTH CARE IN BRITAIN

All British citizens are provided health care through a government-managed **national health care system.** Parliament allocates funds for the health care system and regulates the rates at which general practitioners are paid. Tax revenues provide most of the financing for health care.

Mental health care is available for all British citizens as part of the standard benefit package. Physician services, emergency surgeries, hospital stays, and prescription drugs, along with preventive, home, and long-term care, are all provided by the government. Eye care is not included and dental care is limited. Private insurance is also available.

MENTAL HEALTH CARE IN AUSTRALIA

Australians are provided an interesting mix of health care plans. The government provides a public health plan that covers all public hospitals and physician services. Also available is a national private plan, which supplements the basic public plan. In addition, numerous **private insurance plans** are available for eye care, rehabilitative services, and psychiatric treatment.

National health care is financed by a tax on all citizens above a certain income. Mental health care is not provided in Australia's basic health plan, so treatment for psychiatric disorders is more common for those with large incomes or private insurance plans.

MENTAL HEALTH CARE IN THE UNITED STATES

Health care in the United States is based on the **private insurance model.** Today, more than 75% of United States citizens are covered by private insurance or public programs (Medicare and/or Medicaid). However, more than 15% of U.S. residents do not have any health care coverage.

The distinction between public and private mental health care financing is beginning to blur. Federal funds (Medicare) and state funds (Medicaid) are being used to cover costs in both the private and public sectors. Currently, Medicare funds about 30% to 50% of all state mental health systems.

CARE SETTINGS

Mental health care is delivered primarily in community settings. Admission rates to psychiatric inpatient facilities were at an all-time low in 1983. However, by 1988, hospitalizations for mental illness were on the rise, and emergency departments saw huge increases in clients with psychiatric problems. Today there are more people in need of care than there are treatment settings.

INPATIENT CARE

Individuals are admitted to **inpatient psychiatric care** based on need. The severity of the client's illness, the level of dysfunction, the suitability of the setting for treating the problem, the level of client cooperation, and the client's ability to pay for services all enter into the decision regarding inpatient psychiatric care.

Clients who receive inpatient care remain at the institution for 24 hours per day. There, all aspects of the environment focus on providing therapeutic assistance. Discharge occurs when client behavior has appropriately improved and treatment goals have been attained. The majority of clients are discharged into the community. A few go to a group home or other structured setting.

The most important advantage of inpatient psychiatric care is that it provides clients with a safe and secure environment where they can focus on and work with the problems that brought them there. Clients may also be committed to psychiatric care by way of the criminal justice system. The legal aspects of involuntary commitment are discussed in Chapter 3.

OUTPATIENT CARE

As the emphasis shifts from institutional to community mental health care, the demand for outpatient psychiatric service grows. An **outpatient mental health care** setting is a facility that provides services to people with mental problems within their home environments. With these services, psychiatric clients are able to remain within their communities, associating with the real world.

Community-based mental health care occurs within a dynamic society. Supervision is limited, and the responsibility for controlling behavior lies squarely with the individual. Clients are assessed in

relation to their environment, and therapies are designed to assist them in functioning appropriately within their communities. Unfortunately, the number of outpatient psychiatric care facilities in the United States is being rapidly outpaced by the mental health needs of a nation undergoing many changes. Mentally ill people make use of community services only sporadically. Many wait until major problems occur before seeking treatment. When services are used, a "Band-Aid" approach that treats only the presenting complaint is often used. As a result, many mentally ill individuals who end up in the emergency departments of general hospitals or county jails are in need of inpatient psychiatric care. It is estimated that mental illness affects "up to 20% of prisoners. Between 200,000 and 300,000 incarcerated persons have serious mental illness, with tens of thousands actively psychotic on any given day. The rate of mental illness in prison is as much as 3 times higher than in the general population" (Easley and Allen, 2005).

Unable to cope in the community setting, people with chronic psychiatric problems often return to institutions or use community services on a revolving-door basis. This behavior pattern is known as **recidivism** and means a relapse of a symptom, disease, or behavior. Recidivism is a major problem in mental health care. It is associated with negative treatment outcomes, staff frustration, and inappropriate use of services. Lower rates of recidivism are seen in communities where coordination and cooperation among community agencies and mental hospitals exist.

Psychiatry and mental health care policies are based on the medical treatment model: Identify the symptom and then treat it. This point of view became inadequate once clients were released into the community. A broader, community-oriented, more flexible outlook was needed.

Community Support Systems Model

For mentally ill people to function well within their communities, a wide range of support services is necessary. The **community support systems (CSS) model** views clients holistically—as individuals with basic human needs, ambitions, and rights. The goal of the CSS model is to create a support system that fosters individual growth and movement toward independence through the use of coordinated social, medical, and psychiatric services. Effective community support systems are consumer-oriented, culturally appropriate, flexible enough to meet individual needs, accountable, and coordinated. A typical program may include services such as health care, housing, food, income support, rehabilitation, advocacy, and crisis response (Figure 2-1).

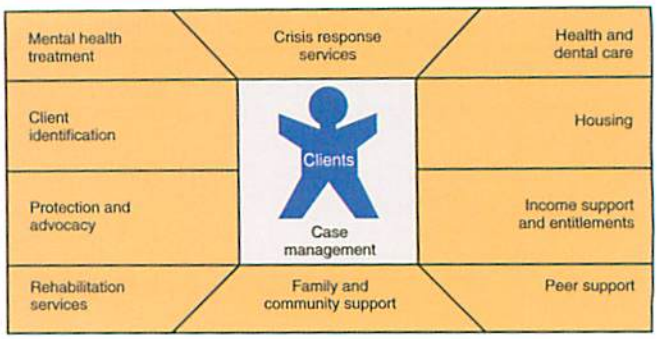

FIGURE 2-1 Community support system.

The most successful **community mental health centers** have forged strong links with community agencies, services, and government. Other centers have developed slowly, but the CSS model of mental health care is proving to be one of the most comprehensive and workable concepts for aiding the mentally ill.

DELIVERY OF COMMUNITY MENTAL HEALTH SERVICES

Mental health services and support systems are available through a variety of community agencies, support groups, and civic organizations. Services focus on prevention, maintenance, treatment, and rehabilitation of mental health problems. Some agencies or groups limit their focus to one area (e.g., Alcoholics Anonymous focuses on treatment of alcohol addiction). Individuals, families, and communities benefit from the activities of various groups. Box 2-2 lists examples of commonly available community services.

COMMUNITY CARE SETTINGS

Community mental health services are based on the needs of specific populations. In addition, mentally ill people must be treated in the least restrictive manner. Therefore, several services are available in various settings throughout the community (Table 2-1).

With short institutional stays and the release of people with chronic mental illness into the community, the need for home psychiatric care providers to fill the gap between institution and community is rapidly growing. Psychiatric clinical nurse specialists (CNSs) ease the transition from hospital to home for clients and their families and assist clients in navigating the mental health care system. They also provide psychosocial crisis interventions and collaborate with clients, families, and other professionals to deliver the most appropriate and cost-accountable psychiatric care. The following Case Study illustrates the role of the mental health CNS in the home care setting.

Box 2-2 Examples of Community Services

SERVING INDIVIDUALS
Rape crisis centers
Churches and synagogues
Employment, job-training agencies
Recreational clubs
Adult education programs
Literacy programs
Mediation groups
Meals on Wheels
Colleges and universities
Mental health agencies

SERVING FAMILIES
Women, Infants, and Children (WIC)
Children's groups (e.g., Camp Fire Girls)
Nutritional services
Church groups
Community "Welcome Wagon"
Recreation centers
Day care centers for young, disabled, or elderly people
Family-planning agencies
Family recreation centers and groups
Shelters for victims of domestic violence

SERVING THE COMMUNITY
Environmental groups
Educational groups (e.g., American Lung Association, March of Dimes)
Utility companies
Community emergency shelters
Governmental agencies
Police and fire departments
Fair housing bureau or agency
Prisons
Performing arts centers
Public forests and parks

Data from Haber J and others: *Comprehensive psychiatric nursing*, ed 5, St Louis, 1997, Mosby.

Table 2-1 Community Mental Health Care Delivery

SETTING	FOCUS/SERVICES	STAFF MEMBERS	COMMENTS
Emergency care (community hospital emergency departments [EDs], emergency psychiatric clinics)	Stabilization, assist with the crisis, refer to appropriate community resources	Nurses, social workers, therapists, psychologists, psychiatric technicians	Many chronically mentally ill use ER settings as entries into the mental health care network
Residential programs (group homes)	Offer a protected, supervised environment within the community	Home care providers, therapists, nurses, technicians, physician	Provide food, shelter, clothing, supervision, counseling, vocational training, socialization
Partial hospitalization (day treatment centers)	Provides care and treatment for clients who are too ill to be independent; clients are gradually introduced into the community	Psychologists, therapists, nurses, counselors, social workers, technicians	Multidisciplinary care and treatment have led to client success and proved the effectiveness of these programs
Psychiatric home care	Delivers care to clients and families in their homes; helps clients and families transition from institution to home; crisis interventions; referral to resources	Psychiatric clinical nurses (CNSs), home care providers	Collaborates with client, family, other mental health professionals to provide ongoing care
Community mental health centers	Services include crisis intervention, family counseling, education, care for the chronically mentally ill, medical care, vocational and skills training	Psychologists, therapists, nurses, counselors, social workers, technicians	Lack of adequate financing has resulted in fragmented services

CNS, Clinical nurse specialist; *ER*, emergency room.

Case Study

Joanne is a 59-year-old woman with severe depression, anorexia, and suicidal ideation. The psychiatric home care referral was an effort by her husband to prevent nursing home placement. Joanne presented with a 30-year history of scleroderma (a disfiguring skin condition), numerous surgeries and hospitalizations, and a 10-year psychiatric history with numerous suicide attempts. She has severe anxiety and agoraphobia (fear of crowds and open spaces). Her anorexia was severe, with her weight at 77 pounds. Medical and psychiatric problems were interwoven, and she needed comprehensive intervention. The clinical nurse specialist (CNS) served as case manager.

Because Joanne could not leave home and needed medication management, a psychiatrist made home visits. Companion services were supplied while the husband was at work. The husband was actively involved in the decision-making regarding his wife's care, but he needed supportive interventions.

Over a 4-month period, Joanne progressed from a severely withdrawn, suicidal person to someone who was dealing with her panic attacks, agoraphobia, and scleroderma. Her weight had increased to 90 pounds. Although she would continue to cope with a chronic illness, her hopelessness was gone, and her ability to function in her daily life had markedly improved. She was able to continue living in her home and community with the help of community mental health services.

- What follow-up care would you plan for Joanne?
- What activities would help Joanne meet her social needs?

Modified from Mellon SK: Mental health clinical nurse specialist in home care for the 90s. *Issues Ment Health Nurs* 15:229, 1994.

CASE MANAGEMENT

Defined as a system of interventions, **case management** is designed to support mentally ill clients living in the community. The major components of case management are psychosocial rehabilitation, consultation, resource linkage (referral), advocacy, therapy, and crisis intervention. Clients are involved with the assessment, planning, and evaluation of their care. Goals are stated as client outcomes. Success is measured in terms of client satisfaction, improved coping behaviors, and appropriate use of services. The overall goal of case management is a successfully functioning client who is able (with support) to avoid relapse and achieve productive patterns of living. A look at each component of case management may help clarify the process.

Psychosocial Rehabilitation

Use of multidisciplinary services to help clients gain the skills needed to carry out the activities of daily living as actively and independently as possible best describes **psychosocial rehabilitation**. Clients are first assessed for physical, social, emotional, and intellectual levels of function. Then specific plans for teaching needed skills are developed. If clients are capable of work, vocational rehabilitation is offered.

The psychosocial rehabilitation model of care encourages decision-making, thus empowering clients. This empowerment fosters a sense of self-esteem and mastery that results in improved coping abilities. As clients feel the success of making their own decisions, they are encouraged to take control over other areas of their lives. Education is also a strong component of psychosocial rehabilitation because mastering daily living skills motivates clients to more productive and independent ways of functioning.

Consultation

In mental health care, **consultation** is a process in which the assistance of a specialist is sought to help identify ways to work effectively with client problems. The case management system relies on the expertise of psychiatrists, nurses, psychologists, social workers, counselors, and various therapists to find ways for clients to receive the services and support that help them to achieve their goals. For example, a nurse might work with a client on personal grooming skills while a social worker locates supported housing and a vocational counselor seeks out an appropriate work setting. By covering all the bases, care providers hope to maintain clients in the community and assist them with their needs.

Resource Linkage

The process of matching clients' needs with the most appropriate community services best describes **resource linkage**. Health care providers have traditionally referred clients to other services, but resource linkage adds the component of periodic monitoring. The advantages of coordinating and linking services are several: Clients can be more easily moved into different programs because background information moves with them; duplication of services is avoided; and as the clients' level of functioning improves, services can be tailored to support the new, more effective behaviors. With resource linkage, the focus for treatment of clients is on care instead of the more traditional emphasis on psychiatric symptoms and illness.

Critical Thinking

You are a health care provider who has recently moved to this area. As a staff member in a community mental health clinic, you are responsible for helping refer clients to appropriate agencies.

- How would you go about locating agencies in the community that provide services for mentally ill individuals?

Advocacy

A critical concept of case management, **advocacy** is providing the client with the information to make certain decisions. Advocacy for mentally ill people involves more than other areas of health care. Advocates work to protect clients' rights, help to clarify expectations, provide support, and act on behalf of

clients' best interests. Every person involved in mental health care can act as an advocate by supporting efforts and policies that encourage healthy living practices.

Therapy

Therapy is provided for each client based on assessed needs, client cooperation, and available services. Medications may be included as part of the overall plan of treatment. Therapies may include the use of counseling, support groups, vocational rehabilitation programs, and techniques to assist clients with problem-solving and adaptive behaviors.

Crisis Intervention

The crisis intervention component of case management is crucial to the success of the client. People with chronic mental dysfunction have great difficulty in coping with stress. What may be bothersome or inconvenient to us could provoke a crisis in someone with mental illness. When problems, frustration, anxiety, or even loneliness become too intense, a crisis erupts. The client becomes unable to cope and retreats into the safety of his or her illness. **Crisis intervention** describes a short-term, active therapy that focuses on solving the immediate problem and restoring the client's previous level of functioning. Crisis services help stabilize the client, prevent further deterioration, and support the client's readjustment process. The use of crisis services also results in better distribution of resources. Emergency department visits decrease, rehospitalization is prevented, and law enforcement resources are better focused on those who break the law instead of apprehending mentally ill individuals. For clients with severe, treatment-resistant mental illness, a new approach, known as **continuous intensive case management,** is being used.

Table 2-2 provides a summary of the continuous care team's treatment activities. In short, care teams direct the client's treatment during all encounters with the mental health care system.

Intensive case management programs have demonstrated that clients with chronic and severe mental illness can be effectively stabilized within the community with appropriate support systems. As the pressures of increased demand for services and cost restrictions force the system into trying new approaches, mental health care professionals must not lose sight of the most important element in the equation—the client.

MULTIDISCIPLINARY MENTAL HEALTH CARE TEAM

Professionals working within the mental health system have various educational backgrounds. In the past, each would work with clients from his or her particular point of view or specialty. This approach resulted in disjointed, fragmented care. In some cases care providers worked at cross-purposes, leaving clients unsure and confused. The need for coordinated assessment and treatment was filled by the concept of the multidisciplinary mental health care team.

CARE TEAM

The main purpose of the team approach to treating mental illness is to provide effective client care. The mental health care team "provides a forum where psychiatrists, social workers, psychologists, nurses, and others can democratically share their professional

Table 2-2 Continuous Care Team Treatment Strategies

SETTING	MENTAL HEALTH CARE TEAM INTERVENTIONS
Community	Meets with clients 2-4 times per week
	Accompanies client to appointments and other community activities
	Helps with daily living/social skill needs
	Monitors medications
	Nurtures relationships with persons interested in client's well-being
	Encourages client to call team instead of using ER
Emergency room	Prearranges for ER staff to notify clinician on arrival of continuous care client
	Conducts assessment of client and planning of care jointly with ER physician
	Avoids unnecessary hospitalizations
Hospital	Care team psychiatrist and primary therapist remain in charge of the client's case
	Helps with decisions regarding admission, treatment, and discharge
	Coordinates treatment with inpatient staff

Modified from Arana JD, Hastings B, Herron E: Continuous care teams in intensive outpatient treatment of chronic mentally ill patients. *Hosp Community Psych* 42:503, 1991.

ER, Emergency room.

expertise and develop comprehensive therapeutic plans for clients" (Haber and others, 1997). The team approach can also be cost effective by preventing duplication of services and fragmented care. Clients and their significant others contribute to the plan of care and remain actively involved throughout the course of treatment. **Multidisciplinary mental health care teams** exist in both inpatient and outpatient settings. The number of team members may vary, but the core of the team is usually composed of a psychiatrist, a psychologist, a nurse, and a social worker. Other team members, known as adjunct therapists, join the team as needed.

Each team member holds a degree or certificate in a specialized area of mental health. This approach allows clients to be assessed and treated from various points of view. As data are compiled, a broad, holistic picture of the client emerges and individualized therapeutic plans are developed. Table 2-3 identifies team members, their educational preparation, and their function.

CLIENT AND FAMILY

No discussion of the mental health team is complete without including the client. As the consumers of services and the focus of therapeutic interventions,

Table 2-3 Mental Health Team Members

TEAM MEMBER	EDUCATIONAL PREPARATION	RESPONSIBILITIES AND FUNCTIONS
Psychiatrist	MD with residency in psychiatry	Physician; leader of the team; responsible for administration and planning; diagnostic and medical functions are main tasks
Clinical psychologist	PhD in clinical psychology	Specializes in study of mental processes and treatment of mental disorders; performs diagnostic testing; treats clients
Psychiatric social worker	Master's degree in social work (MSW)	Evaluates families; studies environmental and social causes of illness; conducts family therapy; admits new clients
Psychiatric nurse	Master's degree; advanced level preparation; baccalaureate degree; diploma nurse; associate degree nurse; licensed practical nurse	Responsible for client's activities of daily living/environment management and individual, family, and group psychotherapy; coordinates care team activities; supervises technicians and psychiatric assistants; active in various community roles
Psychiatric assistant or technician	High school education; special on-job training in setting of employment	Supervised by professional nurse; assists in providing basic needs of clients; carries out nursing functions; maintains the therapeutic environment; supervises leisure-time activity; assists with individual/group therapy
Occupational therapist	Advanced degree in occupational therapy (OT)	Assesses potential for rehabilitation; provides socialization therapy and vocational retraining
Expressive therapist	Advanced degree and specialized training in art therapy	Helps make use of spontaneous creative work of the client; works with groups; encourages members to analyze artwork; adjunct to care team in diagnosis and treatment of children
Recreational therapist	Advanced degree and specialized training in recreational therapy	Provides leisure-time activities for clients; teaches hospitalized clients useful pastimes; uses pet therapy, psychodrama, poetry, and music therapy
Dietitian	Advanced degree and special training in dietetics (RD)	Provides attractive, nourishing meals; helps treat food-related illnesses
Auxiliary personnel (housekeepers, volunteers, clerks, secretaries)	Various backgrounds and on-job training	Assists clients with activities of daily living and other practical jobs; can be invaluable in helping clients
Chaplain	Seminary pastoral counselor or rabbinical education	Attends to the spiritual needs of clients and families; pastoral, marital counseling

Modified from Haber J and others: *Comprehensive psychiatric nursing*, ed 5, St Louis, 1997, Mosby.

clients contribute important information that may make the difference between success or failure of therapeutic plans. Including clients and their families in the treatment process reflects a fundamental change in attitude. Mental illness today is considered to be a manageable, even treatable, complex of disorders.

CLIENT POPULATIONS

Community mental health care was originally designed to provide prevention, education, and treatment services for all members living within an area. Community mental health services for the public include crisis interventions, working with businesses to decrease costs and improve the effectiveness of mental health programs, and providing aid for individuals and families to adjust to life difficulties.

However, certain groups of people are at a high risk for developing mental health problems in every community, large or small. They include more obvious populations, such as homeless people, and more subtle high-risk groups, such as children, families, adolescents, older people, and people who are human immunodeficiency virus (HIV) positive. People living in rural areas present a challenge because of distances among services.

Clients with HIV infection or acquired immunodeficiency syndrome (AIDS) are using community mental health services in ever-growing numbers. Individuals with AIDS face overwhelming physical, emotional, and social consequences. Mental health problems associated with HIV disease include organic problems, such as impairments in memory, judgment, or concentration progressing to dementia. Psychosocial problems include anxiety, depression, adjustment disorders, increased substance abuse, panic disorders, and suicidal thoughts. In addition, many researchers believe that stress directly affects the immune system. Fear of AIDS may hasten the onset of complications. AIDS-related anxiety can increase everyday apprehensions in the lives of many noninfected people.

Comprehensive community mental health services for people with HIV/AIDS are not yet available in all areas. Treatment facilities that offer comprehensive services focus on persons with AIDS, their families and friends, and the public. Clinicians accept referrals from other agencies, provide mental status and suicide risk assessments, offer crisis intervention services, and provide individual or group therapies for clients with HIV/AIDS. Significant others are encouraged to join support groups. Some mental health care centers train family members in techniques for keeping clients oriented or on task. Respite care (time off for the caregiver) services are sometimes coordinated through the center. Some mental health care centers work with interested community groups to provide prevention strategies and education about AIDS for all citizens of the community.

Clients living in rural areas present a special challenge for mental health care providers. Small villages, settlements, and farms dot the country landscape of the United States and Canada. In the United States, rural residents define and relate to health differently from people in cities. Children and adolescents living in rural areas have less access to services. Mental health care providers (e.g., nurses, therapists) who work in rural areas cope with clients of all ages and with all types of problems. They are also expected to provide and coordinate comprehensive mental health care with few available resources.

Other populations, such as **families, the elderly, children,** and **adolescents,** are vulnerable to mental health problems. Community mental health services are a vital link to the well-being of a population. Social and economic changes will continue to influence community mental health care, but as the system matures, the goal of individualized, holistic mental health care for all people should not be forgotten.

IMPACT OF MENTAL ILLNESS

Mental illness affects everyone directly or indirectly. Many people personally know someone with behavioral problems. Indirectly, mental illness costs taxpayers millions of dollars as the costs of care and number of clients continue to escalate. As a result of ongoing armed conflicts, veterans are flooding the system with stress-related disorders. Today, health care reform is part of an overall strategy to distribute scarce resources and control expenses.

INCIDENCE OF MENTAL ILLNESS

Worldwide, 25% of the world's population will experience a mental illness during their lifetime (ASHA, 2011). Although exact statistics are unavailable, it is estimated that at any given time at least 57.7 million adults and 7.5 million children in the United States (National Institute of Mental Health, 2011) suffer from mental-emotional disorders. Chronic severe mental disorders, such as schizophrenia and depression, have emerged as major challenges to treatment. Substance abuse has become a national problem. The incidence of Alzheimer's disease and other dementias is expected to increase threefold over the next 15 years. Social problems such as AIDS, homelessness, violence, and abuse occur with mental problems. Millions of divorces each year place families in crisis situations. It is easy to see why there are growing numbers of mentally troubled people in today's society.

ECONOMIC ISSUES

The nationwide movement to treat people with mental illness in the least restrictive environment is part of a plan to reduce mental health care costs while still providing ongoing care. Unfortunately, funding has not kept pace with the need for services.

To control costs, in 1983 Congress established the **Health Care Financing Administration,** which developed a cost-containment method whereby health care providers are paid at predetermined rates. A group of more than 400 **diagnosis-related groups (DRGs)** classifies each illness. Medicare, the funded health plan for elderly and disabled people, adopted these groups. Payment guidelines, based on clients' average lengths of inpatient stay, determine each DRG. If clients are not discharged from hospitals within the specified time, funding is stopped and the facility or client becomes responsible for payment. Today, mental health facilities provide services for more than 57 million mentally troubled people in the United States. Mental health care costs taxpayers $500 billion a year (Kingsbury, 2008).

Mental illness also influences economics in less direct ways. Unemployed, homeless, and troubled families cost society in many more ways than dollars. Loss of productivity and unfulfilled potential are difficult to appraise financially. Clearly, economic issues have and will continue to play a major role in the availability and delivery of mental health care.

SOCIAL ISSUES

Many social problems are related to mental illness. Changing lifestyles, work patterns, family structures, and health are a few of the many changes that influence a society. Mentally ill individuals, however, are likely to be struggling with more basic issues, such as poverty, homelessness, and substance abuse.

By 2001, nearly 12% of U.S. citizens lived below the poverty line. This means that almost 33 million people, with 6.8 million poor families, live without life's necessities (Procter and Dalaker, 2002). A significant number are incapable of making a living as a result of mental problems. They exist along the fringes of society, attempting to meet the most basic needs of food, shelter, and clothing. Within this environment of poverty, hopelessness grows, and it becomes easier to retreat into one's mental illness than face the grim reality of poverty.

After a time, homelessness becomes poverty's companion. The National Academy of Sciences defines **homelessness** as the lack of a regular and adequate nighttime dwelling. Millions of U.S. citizens are homeless on any given day. About 10% of the homeless are older than 60 years. Many are families, and as many as 85% of the homeless population suffer from addictions or mental disturbances (Walker, 1998).

Homelessness is a national problem that continues to grow. The actual number of homeless people is difficult to count because with no regular housing they tend to melt into society and disappear into the world of soup kitchens and temporary shelters. In the past, most homeless people were single men, usually with alcohol problems. However, today's statistics present a different picture. Women, children, and families now account for many of the homeless people.

Several factors contribute to homelessness. Social conditions, such as a lack of low-income housing, public assistance eligibility requirements, and the movement of chronically mentally ill people into communities that lack adequate support systems, have all had an adverse impact on homelessness. Community resources relating to available housing, steady employment, and welfare services affect homeless people. Family dysfunction, poverty, and health status all relate to the homeless problem.

Many families live from paycheck to paycheck, with just enough money to scrape by until the next check. Even a small event can trigger a crisis. An increase in the rent, for example, may force a family out of their home. Most community mental health centers offer services for homeless people. Currently, short-term strategies for working with the **homeless** population include temporary shelters, assisted-housing programs, and volunteer efforts such as Habitat for Humanity.

Society's use of mind-altering chemicals has resulted in many mentally ill individuals becoming addicted to "recreational drugs," such as crack, cocaine, LSD, and heroin. When used in combination with prescribed psychotherapeutic drugs, overdoses, permanent psychotic states, and death may occur. Street drugs also cost money. It is not uncommon for people with mental problems to spend money on drugs before they buy food. Addicted people with mental disorders suffer from two separate disorders, with each compounding the severity of the other. Illicit drugs and mental illness become a vicious circle.

The current mental health care system in the United States is undergoing major changes as budgets decline, social issues emerge, and needs for treatment grow. Organization and technology may address some of the system's problems, but provider-client contact is and will remain the core of mental health treatment.