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Mental Health Policy through the Lens of a Social Worker

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Mental Health Policy through the Lens of a Social Worker

Abstract
Due to stigma and lack of education, mental health agencies are often the first to receive budget cuts. After conducting research on mental health policy and policy advocacy, the researcher identified an opportunity for social work practitioners to improve mental health policy advocacy, based upon their unique perspective to witness the direct impact of policies on this population. This in-depth literature review encompassed the origins of mental health advocacy, an overview of the mental health system in the United States, barriers to effective service, and best practices in the field of social work. From this research, the author developed a series of recommendations for more effective mental health policy advocacy for social work practitioners.

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MENTAL HEALTH POLICY THROUGH THE LENS OF A SOCIAL WORKER

By

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Abstract

Due to stigma and lack of education, mental health agencies are often the first to receive budget cuts. After conducting research on mental health policy and policy advocacy, the researcher identified an opportunity for social work practitioners to improve mental health policy advocacy, based upon their unique perspective to witness the direct impact of policies on this population.

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Mental Health Policy

Through the Lens of a Social Worker

Introduction

“Social workers promote social justice and social change with and on behalf of clients...Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals’ needs and social problems” (Kelly & Clark, 2009, p. 381). This statement is taken from the Preamble of the Code of Ethics of the National Association of Social Workers (NASW), revised by the 2008 NASW Delegate Assembly. The NASW Delegate Assembly issues a series of policy statements on a range of public and professional issues to guide the positions and actions for social workers in the United States. Based on their unique perspective to witness the direct impact of policies on the mental health population, social workers have an opportunity to influence improvement to mental health policy.

Historically, social workers seek to improve the well-being and meet the basic needs of all people, in particular those who are vulnerable, oppressed, or living in poverty. A person’s mental health is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of all affected by mental illness (World Health Organization, 2012). Mental health service delivery offers a unique challenge to social workers as it encompasses every population that they encounter, including the homeless, children, those living in poverty, the elderly, adults, and adolescents. Mental illness is a medical condition that inhibits the thinking, feeling, mood, and daily functioning within a person and can affect any age, race, religion, or income (National Alliance on Mental Illness, 2011). “Mental illnesses – whatever the term or diagnostic category – have seemingly been an omnipresent feature of the human
condition” (Grob, 2008, p. 89). Simply put, mental illness affects nearly the whole human in race in some way, shape, or form.

Because it is such a prevalent issue, it is the official position of NASW that, “all people in the United States, including immigrants and refugees, be entitled to a comprehensive system of person-centered mental health care” (Kelly & Clark, 2009, p. 234). After studying their statement on mental health care, I conducted an in-depth literature review on the origins of mental health advocacy, a history of the mental health system in the United States, and best practices in the field of social work. From this review, I outlined the major barriers to effective mental health advocacy. Lastly, I developed a series of recommendations to the next NASW Delegate Assembly for more effective mental health service delivery as social work practitioners advocate in order to break down these barriers.

**Origins of Advocacy – Dorothea Dix**

The ethical principle of social justice rests on the notion of pursuing social change for vulnerable and oppressed populations and those who suffer from mental illness are vulnerable and need social change. Creating a more effective method to deliver adequate mental health services is important if we wish to ensure equal access and opportunity to mental health resources. In the nineteenth century, the state began to treat the mentally ill by building and maintaining mental institutions. Dorothea Dix furthered this trend of care for the mentally ill in the 1840s (Trattner, 1999).

Social work pioneer Dorothea Dix paved the way for mental health advocacy. She strived to include the discarded members of society and to give them an equal chance at living a good life. Her efforts are the basis for mental health advocacy as a social worker and Trattner (1999) asserts that Dix was a good example of “sustained constructive action for the
downtrodden” (p. 63) “The general neglect of the mentally ill in America and the common failure to discriminate between idiocy and psychosis, the criminal and abnormal, were due in a large measure to ignorance…and the lack of an aroused social consciousness” (Marshall, 1967, p. 63). This section will address Dix’s work as a mental health pioneer and lobbyist. “Her method of fact-gathering, preparing memorials and bills, and then rallying public opinion behind them, is still of value today” (Trattner, 1999, p. 63).

**Mental Health Pioneer**

“Dorothea Dix was incensed by man’s inhumanity to man. This had, no doubt, been going on for generations…Why had no one ever raised a hand in their defense, or spoken a word on their behalf” (Marshall, 1967, p. 62)? Dorothea Dix was a true pioneer in the mental health advocacy movement and truly embodied the ethical principle of social justice. In the late 1830s, the people of Boston began to evolve an ethical, social ideal, recognizing that man should have a certain quality of life (Marshall, 1967). Dix slowly began to develop a vision for social service as she witnessed the injustices in the state of Massachusetts towards the mentally ill.

She was deeply affected by the inhumanity of it all, and in vivid language she depicted the wretchedness of those poor demented creatures, their suffering, their neglect, their wild frenzy; the guilty, the innocent, the diseased and the unfit, all herded together in unsanitary, inadequate, and in some instances freezing quarters. (Marshall, 1967, p. 61)

By 1840, America had a few hospitals that were doing notable work in the medical field, but the large majority of the mentally ill did not receive the benefits of this treatment. This is when Dix stepped in to help.

Dix first entered the mental health arena after visiting The York Retreat, an asylum for mentally ill patients in England. This visit first triggered her interest in the treatment of mentally ill patients, but it was not until later, while visiting an East Cambridge jail, that she began her fight for changing the entire mental health system (Jansson, 2001). While teaching Sunday
school at the East Cambridge women’s jail, Dix spoke with women who were incarcerated for no other reason than mental illness. She noticed the cold and inhumane environment, also noting that those in charge referenced the women as “lunatics” (Jansson, 2001). As Dix visited prisoners in the Cambridge jail, she began to wonder about the conditions in other prisons and almshouses (charitable housing for the poor) around the state. She quickly began to realize, through trips to other towns, that there were incredible abuses occurring. Dix began to develop the idea that if she did a thorough investigation of every place that housed mentally ill persons and laid these facts before the Massachusetts legislature that they would make changes. She believed that the common people had no idea these abuses were happening because of the public’s limited contact with almshouses, hospitals, and prisons. At this point, Dix began her crusade to convince the public that it was the duty of the state to protect its most vulnerable citizens (Marshall, 1967).

**Mental Health Lobbyist**

Dix had an understanding of legislative reform, realizing that her “natural sensibilities” had to be restrained because a calm manner would suggest a hidden power. Thus, while completing her evaluation, jailers, wardens, and keepers did not resist her entrance into the institutions even though she was going to challenge their actions because she was well known for doing just that (Marshall, 1967). Dix’s most famed work was described as an “unforgettable kaleidoscope of horror, describing in painful detail” (Marshall, 1967, p. 89).

Dix’s *Memorial to the Legislature of Massachusetts* was one of the most remarkable documents of the era. Part legislative petition, part Unitarian sermon, part personal justification, the thirty-page petition transformed her study of prison and almshouse conditions into a fascinating exploration of American society. (Marshall, 1967, p. 88)
MENTAL HEALTH POLICY

Dix then took her crusade to other states, believing that everyone should have the human right to dignity. She fought for ethical treatment of the mentally ill in neighboring states and her first major victory was in Trenton, New Jersey, where she fought for and won the establishment of the State Hospital in Trenton (Jansson, 2001). Additionally, after interviewing more than 10,000 mentally ill persons, traveling 10,000 miles by carriage, and visiting 800 county jails and poor houses, Dix helped establish at least 32 mental health facilities in the following decades (Jansson, 2001).

Dix’s strong convictions and determination made her a crusading mental health advocate. “Refusing to be relegated to the periphery of the legislative contest despite the doubts about her evidence and the rejection of her recommendation, Dix tried to fulfill the promise of her memorial and participate actively in the political fate of the insane poor” (Marshall, 1967, p. 98). Her ideals and beliefs as a pioneer and lobbyist must be put into practice today as we develop modern mental health advocacy methods. A study of the origins of mental health advocacy sets the foundation for building an effective system for social workers.

History of Mental Health Policy in the United States

From the beginning, the United States has had many different positions on mental health policy and has taken a variety of approaches to deliver services to mental health consumers. Inadequate mental health service delivery is a tough problem to solve because of the ever-changing institution of politics. Since its conception, mental health policy in the United States has had changing resources, such as advancements in technology, increasing finances, and innovations in communities. Mental health policy has also witnessed changing structure, with the development of programs such as the Joint Commission of Mental Illness and Health, Community Mental Health Centers, and the National Alliance for the Mentally Ill. This history
of mental health policy in the United States will address the changing resources and the changing structure of the country and how these changes have helped to influence the current mental health service delivery system.

**Changing Resources**

"Theory, however attractive, rarely can encompass reality, which is extraordinarily complex and even messy. Culture, national traditions, political structure, prevailing concepts of disease and illness — to cite only a few — all shaped responses to mental illnesses" (Grob, 2008, p. 90). Mental health policy in the United States has been particularly unique because it was guided by the experiences of the people that fought for independence from British authority. This created a society with inherent tension because of the emphasis on liberty and the distrust of power (Grob, 2008). Despite significant advances in the United States in manpower development and mental health research after World War II, a limited amount of this knowledge was transferred to mental hospitals (Mechanic, 1999). In addition, most states did not have the facilities, financial resources, or people to implement the many innovations of the day (Mechanic, 1999). As the emphasis was moving away from large custodial institutions, hospitals, and resulting costs, towards a discussion of mental health care in the community, the government developed the concept of community care (Mechanic, 1999). They developed these measures not only to reduce costs, but to also bring the community together for the therapeutic value.

**Changing Structure**

With the development of the community concept of mental health care, the government placed emphasis on research and ideals. The Joint Commission of Mental Illness and Health published a report in 1961 that pushed for increased programs and funds for mental health
research. It recommended better training for mental health workers, converting large state mental hospitals into smaller, regional, intensive treatment centers, and new programs for financing community mental health centers, which offered comprehensive mental health care for individuals and families (Mechanic, 1999). However, this period of optimism with an emphasis on the community led to unforeseen problems such as mental health centers releasing patients into the community without proper preparation, services, or consideration of other costs (Mechanic, 1999). During this period, Community Mental Health Centers emerged as the saving grace for the new public mental health approach, with five essential services: inpatient care, emergency care, partial hospitalization, outpatient care, and education and consultation (Mechanic, 1999). These essential services combined with a continuum of care that linked mental health services with other systems, served almost two million people by 1977. Despite these gains, mental health politics were tumultuous.

Although the government developed innovative mental health services, turbulent politics made effective mental health service delivery difficult. The Nixon administration was not sympathetic to mental health concerns and the current programs for mental health centers, research, training, and professional development were largely phased down, phased out, or allowed to fade with inflation (Mechanic, 1999). Consequently, multiple federal mental health initiatives were torn apart, and returned to the states in block grants with funding cuts during the Reagan administration (Mechanic, 1999). Most states understood the importance for the community approach but lacked the resources to fund these necessary programs. Hence, the National Alliance for the Mentally Ill (NAMI) emerged in the 1980s, offering a beacon of hope to mental health policy in the United States.
NAMI entered the arena as an advocate for clients and family members of the mentally ill and continued with vigorous advocacy efforts in the 1980s and 1990s, keeping mental health issues on the national policy agenda (Mechanic, 1999). Concurrently, policy makers debated the location of mental health service (through the National Institute of Mental Health) in the government structure, reorganizing mental health responsibilities. Since this time, the community care ideology, or philosophy, continues to develop. This ideology stems from the realization that the mental hospital isolated patients from the community and developed a level of disability above the level resulting from their condition (Mechanic, 1999). According to Mechanic (1999), this has been a problem because, “ideologies develop more rapidly than patterns of care” (p. 105).

Current Situation

Today, mental health service delivery is far from extensive as, currently, patients stay in mental hospitals for a brief period of time before returning to the community. Numerous chronic patients follow a “revolving-door” pattern of admissions to such facilities (Mechanic, 1999). According to a study, those with serious mental disorders spend less than five hours per year with the clinicians prescribing their medications, and those with less serious mental disorders spend less than fifteen minutes (Freedman, 2009). Accordingly, the proportion of psychiatrist providers to consumers is decreasing. Because of this, mental health service delivery will be left to medical professionals outside of the specific mental health concentration. Mental health service delivery has reflected the inequalities of American medicine because private practitioners serviced those with means, while those who were poor or disadvantaged were ignored, incarcerated, or maintained in large hospitals (Mechanic, 1999). Also, there are increasing needs
in poorer, more rural counties (Freedman, 2009), offering additional challenges for complete mental health service delivery.

In an effort to obtain equality in access to services, the mental health service delivery in the United States has changed throughout the years. However, the current service delivery of the United States health care system has five defining features including: (1) the importance of the institution in delivering care, (2) the role of professionals in the system, (3) developments in medical technology, (4) tension between “caring” and “big business,” and (5) the health care system expenses (Kovner, Knickman, & Jonas, 2008).

First of all, the United States health care system values the importance of institutions in delivering care. This system has developed numerous institutions such as hospitals, nursing homes, community health centers, physician practices, and public health departments that are all intricate institutions that continue to evolve (Kovner et al., 2008). This relates to the second defining feature, as these institutions are largely aware of the importance of professionals in running the system. Physicians, nurses, administrators, policy leaders, researchers, technicians, and business leaders focused on technology and pharmaceuticals, play a large role in running the United States health care system (Kovner, et al., 2008).

Because the system places importance on the institutions and the professionals, logically, the third defining feature of the United States health care system is the developments in medical technology, electronic communication, and new drugs that drive innovations in service delivery. These new advances are a double-edged sword as they make it possible to restore health in new ways, but add costs to the health care system that make health care unaffordable for some in the United States population (Kovner et al., 2008). Due to the growing costs of the health care system, the fourth defining feature is the tensions that have risen between the “caring” and “big
business” culture. Currently, the for-profit corporations, such as insurance and pharmaceutical companies, are dominating the health care system, leading researchers to wonder if health care should operate more as a social good or more like a big business (Kovner et al., 2008). These rising tensions are not unfounded as fifth defining feature of the United States health care system is that the costs of health care continue to rise. The health care system in the United States is expensive to maintain as the country spent $1.988 trillion on health care in 2005, or, one out of every six dollars spent in the economy (Kovner et al., 2008). These unique defining characteristics continue to make the health care system an integral part of the economy and a constant battle in the political system (Kovner et al., 2008).

While the United States health care delivery system has several defining features, the mental health care consumers also have defining characteristics that impact the service delivery. According to Harris Interactive (2008), nearly three in ten United States adults report that they have received treatment or therapy from a psychologist or other mental health professional. This same survey found that younger adults are more open to seeking mental health treatment than those over 50. The most common reasons that consumers seek mental health treatment are for depression and anxiety (2008).

Additionally, there is a bill in the early stages of the legislative process called the Community Assistance Act for Persons with Mental Illness. This bill is just one example of many that are introduced, but it provides insight into the current direction of the mental health policy system. Legislators introduced this bill to encourage states and general local government to use money received under the community development block grant program, the community mental health services, and the substance abuse block grant programs to provide housing, counseling, and financial counseling for people before their release from mental illness.
institutions (2011). It also includes periodic evaluation of the counseling after release. Evaluating mental health service delivery allows for an overview of the system, consumers, and problems.

Through an overview of the history of mental health policy in the United States, including the changing resources, the changing structure, and the current service delivery system, one can begin to evaluate the services being provided. This history provides context for the current barriers and a starting point in developing recommendations to practitioners.

**Barriers**

In order to develop a socially responsible mental health care delivery system, not only do social workers require a strong knowledge base of the issue of mental health policy, but they also need a strong working knowledge of the problems associated with the current policy practice. One of the key aspects of effective advocacy is to be able to identify the biggest needs within the client-base. By researching the biggest needs, social workers can effectively resolve both their clients’ greatest interests and the broader interests of society. I identified three major barriers that are hampering the mental health service delivery system: (1) inadequate funding; (2) health reform and the emergence of mental health services through primary care providers; and (3) inadequate communication between invested parties.

**1. Inadequate Funding**

One of the biggest barriers to effective mental health service delivery is the funding of the entire system. As budgets are cut, programs are eliminated, and institutions are closed, the financial situation in the United States is certainly providing a barrier to mental health service delivery. States require several years to recover after a recession, forcing the State Mental Health Agencies (SMHA) to tighten their belts. These budget cuts and budget shortfalls are
particularly damaging because they affect the consumers of the mental health services in the United States. According to Harris Interactive (2008), financial considerations are the leading barrier to receiving care, both through lack of insurance coverage or concerns over cost. Additionally, “the U.S. burden of mental illness and health and productivity is second only to cardiovascular conditions and a larger percentage than all forms of cancer” (Kovach, 2008, p. 6).

In an effort to be socially responsible, I researched the changing economic climate in SMHA and how this creates a barrier to mental health service delivery.

Before one can accurately evaluate the economic situation of SMHA in the United States, one must assess the economic costs of serious mental illness. “The costs of health care are considered one of the greatest challenges in U.S. public policy. In 2006, health care costs reached 16% of the nation’s gross domestic product, on a path to reach 20% by 2016” (Insel, 2008 p. 663). However, these figures do not fully capture the economic costs of mental disorders because mental disorders are unique to other medical disorders. The major costs of mental disorders are more “indirect” than direct.

Direct costs are those such as medication, clinic visits, or hospitalizations, whereas indirect costs arise from the reduced labor supply, public income support payments, reduced educational attainment, and costs associated with other consequences like incarceration or homelessness (Insel, 2008). In addition, those with serious mental illness have a high rate of medical complications, leading to high rates of emergency room care, high prevalence of pulmonary disease, and early mortality (Insel, 2008). Additionally, there are human costs to be considered as “people with serious mental illness have an average life span 25 years shorter,” and they have higher rates of incarceration, homelessness, unemployment, school dropouts, and the economic loss of caregivers (Kovach, 2008, p. 12). These costs are often easily ignored in
because they are difficult to quantify, but they are extremely important in developing mental health policy. Through the results of a survey extrapolated to the general population, it is estimated that serious mental illness is associated with an annual loss of earnings totaling $193.2 billion (Insel, 2008). This estimated figure demonstrates why funding is such a large barrier to effective mental health treatment.

Once one establishes that mental health service delivery is an incredible expense and research reveals the cost of ineffective mental health treatment, one can examine the budget shortfalls and cuts to the SMHA and the effect this has on mental health service delivery in the United States. In 2010, a study by the National Association of State Mental Health Program Directors (NASMHPD) found that 46 states faced budget shortfalls and the Federal ARRA Stimulus Funding helped, but did not fix the state deficits (Lutterman, 2010). As seen in the chart below, these were the largest state budget shortfalls on record.
Source: (McNichol, Oliff, & Johnson, 2012)

According to the NASMHPD (2008), aside from SMHA budget reductions, Medicaid agencies in several SMHA were reduced and of the thirty-two states with any budget cuts in the next three fiscal years, only four states do not anticipate cuts to Medicaid. These cuts pose significant challenges to mental health agencies as they respond to the cuts in SMHA budgets and Medicaid budgets.

SMHA have felt a significant strain on their budgets and the strain is producing a sizeable effect on these agencies. Due to budget shortfalls, SMHA are closing state psychiatric hospitals and hospital beds, adult mental services are being cut (crisis services, targeted case management, employment, peer support, prescription, housing, clinic services, inpatient care, to name a few), and children’s mental health services are being cut (clinic services, housing, inpatient services,
day services, workforce, prescriptions, targeted case management, among others) (Lutterman, 2010): (see charts below)

Source: (NASMHPD Research Institute, Inc, 2008)
In contrast to the budget cuts and program reductions, “56% of states experienced increased demand for services during the time of budget cuts” (Lutterman, 2010, p. 22). In fact, some states saw an increase of negative signs in their consumers as a result of cuts, including increased unemployment among Mental Health consumers, increased use of psychiatric emergency services or emergency rooms, longer waits for services, more difficult access to care, higher staff turnover, and stress on providers (Lutterman, 2010). As one can see, budget shortfalls and cuts provide a significant barrier to mental health service delivery by decreasing the number of services available and increasing indirect costs. “Without stable funding, no innovation, however effective, is likely to be sustained for very long” (Mechanic, 1999, p. 193).

2. Health Care Reform
Going hand in hand with economic changes is health reform and the effect this has on consumers of mental health services. With the emergence of health care reform, the mental health service delivery system is seeing changes. Federal health care reform focuses on a central role for primary care in health care service delivery and consequently, mental health service delivery is increasingly falling to primary care providers, which means it is important to study how best to integrate mental health services into primary care (Russell, 2010). Suicide is the eighth leading cause of death in the United States, and in 80-90% of these cases (Russell, 2010), people are suffering from mental illness. Despite these statistics, “most mental illnesses are treatable using medication and other therapies”, however, “fewer than half of adults and only one-third of children with a diagnosable mental disorder receive treatment” (Russell, 2010, p. 3). In other words, problems, such as suicide, are a very real prevalent outcome from mental illness, despite most mental illnesses being treatable.

According to Russell (2010), because there are so many barriers to early diagnosis, treatment, and care, it is very important to consider how mental health services could be better integrated into primary care. These barriers include, a failure to link physical and mental health care, a lack of public knowledge of effective treatments, a lack of health insurance coverage, and the still existing stigma. It is important to address these barriers to early diagnosis, treatment, and care because of the treatment gap outlined above. The treatment gap is the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder. This shows that most people in the United States remain untreated or poorly treated, despite the estimated $317 billion economic cost of mental illness (this figure excludes costs associated with incarceration, homelessness, early mortality, and comorbidity) (Russell, 2010).
After outlining the treatment gap, Russell (2010) then discusses the primary issues associated with health care reform. A major issue of concern is the mental health workforce shortage because it implies that a considerable amount of mental illness care is provided in the non-mental health sector (Russell, 2010). Better incentives for people to enter the field and better use of technology address the issue of workforce shortages. Another issue of concern is the fact that, even though the use of primary care to treat mental health has grown, the quality of treatment has not improved. This can be improved through better training and tools and the use of a team approach (Russell, 2010).

Health reform also creates financial difficulties. First of all, there is a lack of financial incentives for primary care providers because cost creates a disincentive for comprehensive mental health screening. However, increased financial incentives and consistency in Medicare and Medicaid policies offer a possible solution (Russell, 2010). This system likewise creates insurance and financial barriers for patients, which can be fixed by ensuring that all have access to affordable health insurance coverage (Russell, 2010).

Lastly, health care reform affects patient’s perceptions and fears because they are reluctant to seek care for mental health problems. Russell (2010) suggests reforming these perceptions through public education and awareness, a focus on recovery, and protection against discrimination. Russell (2010) is also concerned about the quality of mental health services, comorbidities with physical illness and substance abuse, the need for an early diagnosis, racial and ethnic disparities, and the structure of the health care system. She also believes that there are three crucial elements that are needed in the mental health care system: protection against discrimination through education, awareness, and training; better integration of the systems for addressing mental and physical health and substance abuse to improve the quality of life and
reduce health care costs; and more youth-specific services because early identification and
treatment is key to being cost effective and proper development (Russell, 2010).

As health care reform shifts the burden of mental illness into the primary sector, the
system must be cognizant of these changes. This shift is not necessarily a bad thing for the
mental health system, but if it continues in this direction, primary care providers need to have
proper training, resources, and education across disciplines or quality and outcomes for mental
health patients will decline.

3. Inadequate Communication

Due to the fact that much of the care for the mentally ill is now left to the primary care
physicians, communication is key to obtaining an effective mental health service delivery
system. "The ethnography of language policy is a method for linking micro-level educational
practices with macro-level language policies and discourse" (Johnson, 2009, p. 156). The
language of policy becomes a critical issue in the mental health service delivery arena. Outside
of the context of mental health, Johnson (2009) continues to say that to understand language in
policy, "one must consider the (1) agents, (2) goals, (3) processes, and (4) discourses..., and (5)
the dynamic social and historical contexts" (p.144). An integral part of the language of policy is
how this policy is communicated and who communicates the ideals. Stigma and perceived
barriers to mental health service highlight the necessity for a more open language and
communication discourse in the mental health community. According to Dr. Richard Millard
(2008), Group President of Harris Interactive, "It’s a paradox of sorts that therapy for mental
health has become commonplace and rather normal, even though a sizeable proportion of
Americans say it’s either difficult to afford, or hard to understand how it works" (para. 3).
In 2007, a study examined and compared the perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. What emerged was a distinct set of differences between these locations, giving the authors insight into the United States mental health care system because it allowed them to compare and contrast the perceptions of mental health service utilization in the United States with other Western countries. Being able to compare to other similar countries with differing health care systems allowed the authors to see barriers to effective mental health care in the United States.

This study offered a look into the communication difficulties in the United States mental health system. Individuals with a mental disorder diagnosis were more likely than those without a mental disorder to report that, "help probably would not do any good," and a fear of involuntary hospitalization (Sareen et al., 2007, p. 359). Also, survey respondents in the United States were much more likely than those from the Netherlands and Ontario to report that they wanted to solve the problem on their own and were not sure where they should go for assistance (Sareen et al., 2007). From this, one can conclude that attitudinal barriers to mental health service are as problematic as structural barriers (Sareen et al., 2007).

According to Harris Interactive (2008), several communication difficulties prevented people from seeking treatment. (1) Two-thirds of U.S. adults cite a basic lack of understanding about the treatment process itself, including a lack of confidence in the end result, a lack of knowledge about how to find the right services, and not knowing if it is suitable to seek assistance. (2) 67% of respondents stated that they might not seek treatment due to access to care, including cost and lack of insurance. These statistics represent a large barrier in the form of perceived barriers, which are almost more damaging than actual barriers. This lack of
knowledge increases the cost of untreated mental illness because consumers either do not have faith in the care system or do not know how to find the proper services.

Due to stigma and other perceived barriers, those in need of mental health care are not seeking out treatment, are not receiving adequate treatment, and are increasing the costs to society because of untreated mental health problems. All of these problems represent a lack of communication between consumers and policy makers in two ways. There is a lack of communication about the effectiveness of mental health services and a lack of communication about how to obtain proper services which leads to inadequate mental health service delivery. The shifts into the primary care sector also present a lack of communication across disciplines and can be equally as detrimental.

Identifying the barriers to adequate mental health service delivery help to create a more efficient system. Understanding the barriers and the effective programs already in place help to develop recommendations for improved mental health service delivery.

Examples of Best Practices in Mental Health Service Delivery

In an effort to improve the mental health service delivery in the United States, we do not necessarily have to reinvent the wheel. Often, the best solutions to these barriers are already in place within existing programs that can serve as models. Research must be done surrounding model programs in place, evidence-based research, and the current legislation. Rather than developing an entirely new program, a successful program could evolve from the coordination of multiple existing solutions to the issue of inadequate mental health service delivery. I identified three model programs within mental health service delivery – The Comprehensive Community Mental Health Services for Children and Their Families Program, Rural Health Care: New Delivery Model Recommendations, and Position 12: Evidence-Based Healthcare. These
programs offer a foundation for developing an effective mental health service delivery system in the United States.

**The Comprehensive Community Mental Health Services for Children and Their Families Program**

Since 1993, in an effort to change the mental health system in the United States, the Comprehensive Community Mental Health Services for Children and Their Families Program (Children’s Mental Health Initiative, or CMHI) has served more than 70,000 children and their families (Miech et al., 2008). This program is based on a system that builds on the principle of collaboration, believing that outcomes will improve among children, youth and families when organizations collaborate to provide coordinated service delivery. A comprehensive program evaluation found that the program was effective in achieving its goals of increasing community service capacity and providing a broad array of treatments and community supports. According to the Annual Report to Congress by the center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005), and U.S. Department of Health and Human Services, CMHI successfully integrated coordinated services and saved significant costs.

Over the past several years that this program has been in effect, each community involved has evolved and refined their individual system of care models. As part of the holistic, community model, CMHI balances Medicaid funding with other sources that focus on other issues that children face, other than mental health (Miech et al., 2008). This approach holds promise for a successful and sustainable service delivery model because it has the potential to provide a more lasting reduction to mental health problems and disparities.

**Rural Health Care: New Delivery Model Recommendations**
This report from the New Rural Health Care Delivery Model Work group (2009) examines the effect of health reform on rural health service delivery, addresses the specific challenges to delivering health care in rural areas, and makes recommendations for delivery coordination and systems integration.

Rural areas face unique challenges to delivering health care including provider shortages, isolation, long travel distances, scarcity of specialty care, under-resourced infrastructure, and a predominately older population with many chronic conditions (2009). In addition, the United States has many problems with health care that likewise affect service delivery. The health care system is highly fragmented and episodic, there is an over-reliance on specialized care, care is inefficient, and the funding creates incentives for treatment rather than prevention.

However, while lacking in some areas, the rural health system also holds some advantages based on its service delivery. The rural system (2009) is based on a more linear model that offers a continuum of care. Much like the Comprehensive Community Mental Health Services for Children and their Families Program, rural mental health care incorporates several aspects of health care, beyond traditional mental care. Rural hospitals are better able to coordinate with community organizations and work with local health needs to develop successful health programs.

Among their recommendations, the New Rural Health Care Delivery Model Work Group (2009) specifically focuses on health care delivery coordination and integrating systems. This group recommends highlighting the importance of coordination and inter-professional care starting with higher education and training. This group also recommends that improving communication will assist in removing barriers. Communication and technology subsequently improve networking, professional training, and access to community resources. Lastly, a key
recommendation from the Work Group (2009) focuses on payment reform. In the current system, health providers have few reasons to collaborate with each other. Collaboration will help providers share resources, be more efficient, and expand basic services.

**Position Statement 12: Evidence-Based Healthcare**

According to Mental Health America (MHA) (2011), effective access to reliable, evidence-based practice is imperative to the informed decision making process between health consumers and providers. This position says that health care delivery must be driven by scientific knowledge, clinical expertise, and consumer and family experience and values. The purpose of this is to relay evidence in a form that is accessible to the general public (Mental Health America, 2011).

This position of MHA (2011) is integral to mental health service delivery because it allows for an opportunity to improve the quality of mental health care because it will “empower consumers to seek and demand continually improving care and services and ensure consistently better and more meaningful outcomes” (MHA - Opportunities & Challenges, para. 1). MHA asserts that identifying key questions for future research that are most important to consumer outcomes will empower consumers. MHA (2011) lays out four principles for evidence-based healthcare: (a) Transparency – the process to evaluate and develop evidence-based programs should be open to the general public to be included as stakeholders in the process; (b) Individualized Care – Reimbursement and coverage policies should be individualized to reflect each consumer’s needs; (c) Consumer-Relevant Outcomes – Focus the evaluation on quality of life outcomes, rather than symptom management; (d) Cultural and Linguistic Competence – Mental health care practices should be catered to the cultural and linguistics groups being served.
A study of best practices in the field provides a framework for developing effective services. The programs that are already in place, such as The Comprehensive Community Mental Health Services for Children and Their Families Program, Rural Health Care: New Delivery Model Recommendations, and Position 12: Evidence-Based Healthcare, offer insight into which practices will be effective and which will not. It becomes much easier and more efficient to create recommendations for improved advocacy with a foundation of model programs and evidence-based health care.

**Recommendations**

Competence is important to effective mental health advocacy by social workers because without it they will not be able to convince legislators they are worth listening to. In order to be taken seriously in the professional arena and truly make an impact, social workers must exhibit competence in the specific knowledge of their chosen field in order to effectively advocate for the disadvantaged mental health population. I propose four recommendations to help continually improve the social work policy statement on mental health and therefore improving the potential impact in the mental health policy advocacy arena. These recommendations are to: (1) improve communication, (2) increase involvement in politics, (3) implement constant evaluation, and (4) utilize knowledge of the institution of politics.

1. **Improve Communication**

   Social workers should improve communication to consumers, policy makers, and across disciplines in order to knock down perceived barriers that prevent consumers from receiving adequate care. Improved communication within the sources of funding and the law is necessary to generate a more effective mental health service delivery system.
Improved communication is a very important recommendation because it encompasses three components of mental health service delivery: consumers, policymakers, and across disciplines. It is important to banish the perceived barriers and stigma that prevent consumers from receiving adequate care. The NASW policy statement addresses the importance of reducing stigma. “Social workers should advocate for the elimination of stigma associated with mental illness” (Kelly & Clark, 2009, p. 234). However, social workers should address the perceived barriers to mental health service utilization, such as fears of the mental health service, attitudinal barriers, and lack of faith in the system. (See: Barriers – Communication). In this case, failure to communicate the successful outcomes of mental health treatment is detrimental to the system considering the indirect costs garnered from untreated mental illness.

Additionally, it is important to have effective communication between policy makers and social work lobbyists. (This will be addressed in more detail within the fourth recommendation.) As mentioned in the Ethnography of Language Policy, communication in policy must consider the agents, goals, processes, discourses, and dynamic and historical contexts (Johnson, 2009). In order to gain any ground, social workers must be cognizant of those who have the ability to enforce change and how they should best communicate these ideals. Policy makers have the power to enact policy to change the system, so it is important for social workers to be knowledgeable of the agents involved and how to best communicate the need for change to these influential people. Until there is no longer stigma or perceived barriers surrounding mental health, social workers should continue to improve methods and delivery of communication in the realm of politics.

Lastly, it is important to improve communication between all service delivery systems through increased collaboration outside of the realm of social work. NASW asserts that, “social
workers should recognize outreach services as an important part of mental health services,” and “a more integrated system of care should be developed” (Kelly & Clark, 2009, p. 234-235).

However, there needs to be a specification of collaboration across disciplines. “The need to work with others, across disciplines and across professions is the only realistic way to address the complexity and interconnectedness that describes the service user’s experience” (Howe, 2009, p. 7). Nearly every model program and best practice in the mental health field stressed the importance of collaboration. The Comprehensive Community Mental Health Services for Children and Their Families Program was built on the principle of collaboration. Coordinated service delivery across systems will save costs and balance sources of funding, which will make the legislature more apt to listen to social workers as the budget is often the major concern. Social workers need to push for this collaboration between all service delivery sectors.

Additionally, Rural Health Care: New Delivery Model Recommendations found a continuum of care to be successful. This is a useful recommendation for social workers because it not only focuses on delivery coordination and integrating systems, but also incorporates several aspects of health care, beyond the mental health care. Currently, the health care system is fragmented, with an over-reliance on specialized care, which is inefficient in the long term. Collaboration across the health care disciplines will improve the efficiency of mental health service delivery, which will in turn improve training, resources, and technology for mental health consumers. Collaboration within the social work profession is also important, but serious strides can be made with further efforts to unite disciplines working in the mental health field and to gain new perspectives.

Additionally, Hogan (2002) outlines that funding is not necessarily the biggest problem, but that too much money is being spent on mental illness in the wrong places. This suggests that
the United States does not necessarily need to delegate more money to improve the mental health service delivery system, but improved communication to policy makers about actual needs of the population could reap significant improvements to the system. “The excess costs of untreated or poorly treated mental illness in the disability system, in prisons, and on the streets are part of the mental health care crisis...It is evident that our past advocacy tactics have generally not worked to generate equitable investments” (Hogan, 2002, para. 10-11).

Improved communication by social workers about the actual needs of the mental health population and how to best achieve these ends will improve the service delivery as a whole. Increased communication to consumers, to policy makers, and across disciplines will improve the success and efficiency of mental health service delivery in the United States.

2. **Increase Involvement in Policy by Social Workers**

Social workers should increase their involvement in the policymaking and lawmaking process by running for public offices, such as senators or representatives. NASW mandates that social workers “take the lead in advocating for viable, comprehensive, community-based mental health services...this responsibility includes efforts to influence public policy” (Kelly & Clark, 2009, p. 235). I absolutely agree with this statement, but would like to see an addendum to this policy statement. Social workers are currently advocating and lobbying for change to improve the lives of disadvantaged populations. However, vulnerable populations will largely benefit from an increased involvement in the actual decision-making in politics. “Key elements in building appropriate and effective sources of community health care are the organizational and financing systems and policy decisions concerning the populations” (Mechanic, 1999, p. 193).

Involvement in policy can take many forms, from writing letters to Congress, lobbying on Capitol Hill, or becoming an active member such as a senator or representative. Becoming an
active member in the policymaking process itself is crucial because social workers can provide strong leadership in policy, utilizing the effects they witness in their clients.

Social workers could be instrumental in passing mental health parity legislation, which could be a significant part of the solution. "Parity legislation is needed because health insurance discrimination contributes to stigma that prevents people from seeking treatment" (Kovach, 2008, p. 17). She also asserts that parity legislation will reduce government costs by shifting to the public sector and it will attend to the social costs of untreated mental health problems by reducing stigma (Kovach, 2008). Social workers would have a critical voice in politics because they see the effects of the policies in place firsthand and can understand how to craft effective mental health parity legislation. Michigan Senator Debbie Stabenow is an example of this strong leadership as she is trained as a social worker. She is able to use her training and knowledge to influence policy effectively.

It is evident that in order for the issue of inadequate mental health service delivery to be properly addressed, there must be strong leadership at the highest levels of government and policymaking. Who better to provide this strong leadership than social workers, who have seen the impacts of the problem firsthand?

3. Implement Constant Evaluation

Social workers should constantly evaluate mental health practices, using the consumers as the crux of this research. NASW asserts that social workers, "should involve family members and significant others in assessment and treatment planning," and "social workers should engage in research or advocate for further research on mental health issues" (Kelly & Clark, 2009, p. 235). These policy statements clearly emphasize the importance of current research and assessment. This recommendation emphasizes constant evaluation of all programs and policies.
During her advocacy, Dorothea Dix recognized the incredible importance of assessment as she traveled to every place that housed mentally ill in the state of Massachusetts.

However, using consumers to assist during the process would improve this evaluation. This constant evaluation should utilize the consumers to establish their perspective and needs. Rather than simply including consumers in the process of deciding what to evaluate, they should be an important part of the actual assessment. As Mental Health America (2011) says, evaluation should be open to the general public to include them as stakeholders in the process. Evaluation is the driving force of research because it provides the necessary direction to decide what the problems are and how to solve them. Social workers should push to include consumers in the evaluation process because of their firsthand knowledge of how mental health services impact those in need.


Social Workers need to gain and use knowledge of the political institutions in order to effectively communicate their concerns. The institution of policy is composed of several parts and it is important for any social worker to be knowledgeable of this system and how it functions in order to be a successful advocate. In their policy statements, NASW mentions the importance of policy advocacy, but it should clearly outline the best approach.

The Citizen's Guide to State Government (2012) likewise addresses this issue as it educates the public about communicating with legislators. This guide states that one does not need an impassioned crowd to make a point; one or two well-informed lobbyists will be more effective and less confusing to legislators in the long run. The Citizen's Guide also states that well-prepared facts and a calm, reasonable attitude will be much more effective at gaining the respect and attention of policymakers rather than a large and impassioned crowd. This is not to
suggest that passion should be omitted entirely, but it should be artistically molded into the policy advocacy to most effectively display the outcome and why it would be beneficial to the government. Dorothea Dix understood the need to know her audience as she worked to inform the Massachusetts Legislature. Despite being incensed about the cruelty she witnessed, Dix maintained a calm manner and did not allow her personal feelings to intrude in the politics. She still maintained her passion and persistence, without allowing it to interfere with the outcome. Since her efforts are still being studied hundreds of years later, her calm and reasoned method is proven to also be an effective mode of change. Understanding political institutions better will help social workers advocate for much needed changes because they will have a much clearer idea of how policies are made and who makes them, which will help advocates pull the right strings when trying to improve the lives of this vulnerable population.

Using the knowledge of the history of advocacy, current research, and best practices, these recommendations will serve as guidelines to improve mental health service delivery. Social workers can use these recommendations to improve their advocacy as they encounter mental health issues within all populations that they work.

**Conclusion**

After a study of the origins of mental health advocacy, an overview of the history of mental health policy, and a study of the best practices currently in place, I discovered three major barriers to adequate mental health service delivery: inadequate funding; shifts due to health care reform; and inadequate communication with consumers, with policy makers, and across disciplines. In order to dismantle these barriers, I proposed four recommendations for social work practitioners to the next NASW Delegate Assembly. These recommendations act as strategies to improve mental health advocacy and they include: improved communication,
increased involvement in politics, implement constant evaluation with consumers playing a vital role, and to utilize knowledge of the political institutions.

Advocacy means everything to the social work profession and its commitment to social justice. It is a social worker's duty to constantly evaluate effective methods for advocacy on behalf of all vulnerable populations and to become proponents of change in society. As spoken by Colleen Patrick-Goudreau, "Don't do nothing because you can't do everything. Do something. Anything."
References


http://www.cbpp.org/files/9-8-08sfp.pdf


Michigan Legislature, (2012). *Citizen's guide to state government*


