CHAPTER 1

SOCIAL WORK AND THE MENTAL HEALTH SYSTEM

LEARNING OUTCOMES

- Compare and contrast definitions of *mental health* and *mental illness*.
- Describe the prevalence of mental illness in the United States.
- Define *stigma* as it applies to individuals with mental illness.
- Analyze the impact of the media on concepts of mental illness.
- Explain social factors that contribute to mental health problems in American society.

INTRODUCTION

The concept of mental illness suggests many different and disturbing images and stereotypes. For example, as shown in television advertisements for antidepressants, there is the image of a woman with her head hanging appearing to be devoid of energy, looking forlorn and hopeless. There is the image of a man seemingly angry and very upset. Media depictions often attribute crimes of violence to those persons whose behavior is out of control due to a raging mental illness. However, mental illness is often a private kind of suffering for individuals and their families. Overall, we prefer to view those with mental illness as somehow different from ourselves. In fact, many of us will endure some form of mental illness in our lifetimes.

What, then, is mental health? Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Further, mental health is important at every stage of life, from childhood and adolescence through adulthood. Factors that contribute to mental illness include biological factors such as genetics and

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brain chemistry and may be related to a family history of mental health problems. Life experiences such as childhood abuse and trauma are also associated with mental health problems.

Mental disorders, like mental health, impact a person's thoughts, feelings, moods, and behaviors. For some persons with mental illness, their disorders are chronic, lasting their entire lifetime. Other individuals may function well most of the time, yet have periodic episodes of mental illness that are a challenge for them and others. In reality, mental health cannot be separated from physical health, and mental disorders are underestimated due to a failure to appreciate the connection between other health conditions and mental illness (Prince et al., 2007).

This chapter reviews global ideas about mental health and addresses the stigma associated with mental illness that is often exacerbated by the media. It provides an overview of mental illness in the United States today. The chapter also begins our examination of the role of mental health social workers in providing services and developing policy. Part of this examination seeks to apply the core competencies of social work to mental health as determined by the Council on Social Work Education (CSWE), the accrediting body of social work undergraduate and graduate programs. See Tips for the Field 1.1 for the nine core competencies of social work that can be adapted to address the policy, research, and treatment needs of those with mental illness.

TIPS FOR THE FIELD 1.1

CORE COMPETENCIES OF THE COUNCIL ON SOCIAL WORK EDUCATION

In 2008, the CSWE changed its academic orientation to support competency-based education. Instead of focusing on curriculum design and organization, the CSWE took the position that social work education should focus on student learning outcomes. To reflect this stance, the Educational Policy and Accreditation Standards were revised in 2015, which resulted in the current nine core competencies. These core competencies of the CSWE are easily adaptable to the treatment of mental disorders:

1. *Demonstrate ethical and professional behavior*. The first core competency is a hallmark of the social work profession. With this profession long recognized as having one of the strongest professional codes of ethics, ethical behavior is at the very heart of the social work profession. In this text we will see the challenges of maintaining these ethical standards in the treatment of those with mental illness.
2. *Engage diversity and difference in practice*. The second core competency focuses on cultural competency and encourages equitable treatment for diverse populations. There are numerous examples that illustrate the potential for differential treatment according to race and ethnicity, especially within the criminal justice system. Mental

health services must be provided to individuals and families of color by a diverse group of professionals.

3. *Advance human rights and social and economic environmental justice*. The third core competency addresses the history of the social work profession and its commitment to ensuring access to mental healthcare and the role of social work in developing a just American society. Today's mental health system is not necessarily just and can be rife with prejudice that has long-term negative consequences for the poor and people of color. An essential factor is that justice must be available to all in both access to and quality of care.
4. *Engage in practice-informed research and research-informed practice.* The fourth core competency underlies the social work profession; there is a clear need to determine what works and what does not in the treatment of mental illness. Social work knowledge and skills must be acquired and applied through a continuous learning process that consistently seeks improvement over time.
5. *Engage in policy practice.* The fifth core competency addresses the need for members of the social work profession to acquire leadership and policy development skills in addition to clinical skills. Social workers have the knowledge and experience to make important contributions to mental health policy and need to increasingly seek these kinds of professional policy and leadership positions.
6. *Engage with individuals, families, groups, organizations, and communities.* The sixth core competency corroborates that social workers possess the critical skills needed to engage clients and their families in mental health treatment. Social workers must bring community attention to the needs of the mentally ill and improve mental health advocacy and advocacy organizations.
7. *Assess individuals, families, groups, organizations, and communities*. The seventh core competency supports social workers in their work, including determining the appropriate types of treatment for individual clients and their families. As much as possible, these assessments and recommendations for treatment should be free of bias.
8. *Intervene with individuals, families, groups, organizations, and communities*. The eighth competency addresses the wide variety of social work interventions necessary to ensure the appropriate provision of mental health services. Additionally, interventions must support the effort to overcome individual and community obstacles to providing mental health treatment.
9. *Evaluate practice with individuals, families, groups, organizations, and communities*. The ninth and final competency relates back to the fourth core competency, which states that research and program evaluation are critical in determining effective treatments for those with mental illness. Social workers in clinical settings are in a very good position to assess and implement effective treatment protocols. Overall, social work interventions with the mentally ill must be developed, tested, and evaluated to determine what works best.

SOURCE: Council on Social Work Education. (2015). *2015 education and policy and accreditation standards for baccalaureate and master's social work programs*. Alexandria, VA: Author.

GLOBAL IDEAS ABOUT MENTAL HEALTH

No one is a stranger to stress; indeed, many people today are living under extreme stress. Stress is associated with experiences of mental as well as physical illness, with a host of illnesses being triggered or exacerbated by stress. Stress is clearly a worldwide phenomenon. In 2017 alone, the United Nations refugee agency reported 68.5 million refugees around the world had to flee persecution, violence, and/or war (Associated Press, 2018). It is hard to imagine anything more stressful than having to leave one's homeland with no guarantee of safe passage to a protected environment for oneself and family. We are naive to think these experiences do not pose mental health risks for those who must endure the challenges of being unwanted immigrants and refugees.

Estimates from the World Health Organization (WHO) show the magnitude of mental health problems around the world. Approximately 300 million people worldwide suffer from depression (WHO, 2018a, 2018b). Bipolar disorder affects approximately 60 million people, and schizophrenia is estimated to affect 23 million people (WHO, 2018a, 2018b).

In American society, we are constantly bombarded with images of violence from around the world. This exposure begins at very early ages, with the many images of war and natural disasters that we see on the daily news. We see refugees fleeing worn-torn countries, only to be turned back. On television we watch Syrian children gagging and trying to breathe after being gassed by their own government. We see losses attributed to nature such as the 2017 devastation of Puerto Rico by Hurricane Maria and surviving residents coping with posttraumatic stress, including anxiety and depression (Daily Briefing, 2017; *New York Times*, 2018). We see the stress of immigrants in the United States facing deportation under President Donald Trump and families ripped apart in the process, including the separate detention of parents and children of all ages at the Mexican border (Linsky, 2018).

It is very difficult to determine the number of people across the globe who live with constant stress as well as the myriad health conditions that negatively impact mental health (Anderson & Jane-Llopis, 2011). The development and expansion of research on the impact of natural and human-made disasters on children are of great importance. The vulnerability of children is evident due to their undeveloped or underdeveloped coping skills (Grolnick et al., 2018). Their reactions to stress may include anxiety, depression, and grief that can result in posttraumatic stress disorder (PTSD). Previous mental health problems can worsen or new mental health issues can develop as children react to trauma. The numerous and devastating school shootings in the United States can leave child and adolescent victims as well as witnesses with long-term consequences.

Interventions immediately after trauma, known as *psychological first aid* or *psychological debriefing*, are considered promising; however, more research is needed. The fact that school shootings are now commonplace led to the development of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a model for providing services to children and adolescents who have experienced school shootings (Grolnick et al., 2018).

Mental disorders are closely related to other health conditions, but more must be discovered about those connections. Mental illness in every culture can be linked to chronic illnesses associated with lifestyle factors such as poor diet, smoking, obesity, and high blood pressure. A mental illness can make it harder to adhere to a medication regimen (Prince et al., 2007). Physical injury can both be caused by and result from mental illness. Food insecurity, a huge problem in today's world, is also associated with the development of mental health disorders in children and adolescents. The more inadequate children and adolescents' nutrition, the more likely they are to develop a mental health disorder (Burke, Martini, Cayir, Hartline-Grafton, & Meade, 2016).

Unfortunately, mental health is not typically considered an urgent concern in developing countries, where eradicating infectious disease is the priority (Nii-Trebi, 2017; Prince et al., 2007). Key goals of the WHO in 2015 included the promotion of research on mental health and the reduction of substance abuse around the world (WHO, 2018b). The Centre for Global Mental Health (CGMH), located in the United Kingdom, is a pioneer in supporting research, promoting access to care, and ensuring the prevention and treatment of mental health problems, especially in poor countries that have few health resources (CGMH, n.d.). Its Mental Health Innovation Network (MHIN) promotes the sharing of innovations among researchers, clinicians, and policy makers to improve global mental health.

As we will see in this text, culture has strong bearing on attitudes toward mental health and mental illness. In a study comparing mental health professionals in Brazil with mental health professionals in Switzerland, Brazilian professionals held a more positive attitude toward providing psychiatric services within the community, whereas Swiss professionals held greater stigmatizing attitudes and showed a preference for prescribing medications over other interventions (Des Courtis, Lauber, Costa, & Cattapan-Ludewig, 2008).

Overall, more attention must be paid to global mental health and well-being as well as to individual and community resilience. Much more can and should be done to promote the mental well-being of citizens of all nations. This includes promoting strong social networks and living environments that support physical and mental health (Anderson & Jane-Llopis, 2011). These efforts will become even more critical as

the world copes with climate change and the knowledge that ice caps in Antarctica are melting three times faster today than they were 10 years ago (Pierre-Louis, 2018). To further promote change, global mental health initiatives must obtain greater prominence, funding, and support from global political leaders (Tomlinson & Lund, 2012). Global strategies are necessary to reduce the stigma of mental illness, develop evidence-based practices, and support innovative approaches to treatment (Tomlinson & Lund, 2012). Unified social justice and human rights approaches are also necessary to gain the attention of policy makers. Lastly, key interventions on a global level must consider local, national, and international politics (Sawyer, Stanford, & Campbell, 2016).

MENTAL ILLNESS IN THE UNITED STATES

The magnitude of mental disorders is underestimated in the United States. This can be attributed in part to the divorcing of mental health disorders from other kinds of health problems (Prince et al., 2007). However, it is clear that concerns for mental health should be an integral part of social and health policies (Prince et al., 2007). Varying estimates of mental health problems can be attributed to the use of different questionnaires, how the questions are administered, and whether findings of specific studies can be generalized beyond a specific sample (Bagalman & Cornell, 2018). There is also a distinction between having symptoms of a specific mental health problem such as depression and not seeking treatment, and having depression diagnosed by a mental health professional. Some surveys include substance use disorders as a mental health problem, whereas others distinguish between mental health and substance use disorders. The distinctions and intersections between mental health disorders and substance use disorders are examined in Chapter 5, Social Work and Mental Illness: Labels and Diagnoses.

The best-known and most comprehensive national survey on mental health and substance abuse is the National Survey on Drug Use and Health, administered through the Substance Abuse and Mental Health Services Administration (SAMHSA). This survey is completed each year and consists of interviews with approximately 68,000 people age 12 and older. The survey collects data on substance use and mental illness. For substance use, data are collected on tobacco use, alcohol use, illicit drug use, substance use disorders, and substance abuse treatment. For mental illness, data are not collected by specific mental health diagnosis but rather according to the following categories: major depressive episode (within the past year), mental illness among adults, co-occurring mental illness and substance use disorders among adults, suicidal thoughts and behavior among adults, and mental health service use among

adults. For adolescents, data are collected on major depressive episodes and substance use (SAMHSA, 2017). Thus, data are collected in major categories without a specific focus on clinical diagnosis of individuals.

In 2016, it was estimated that 18.3% of American adults age 18 and older had some kind of mental illness during the previous year. It was estimated that 4.2% of American adults had *serious* mental illness (SAMHSA, 2017). Among adolescents age 12 to 17, 12.8% had a major depressive episode. Of those adolescents, only 40.9% received treatment for depression. The mental health problems of adolescents are addressed in Chapter 4, Mental Illness Across the Life Cycle: Children, Adolescents, Adults, and Older Adults.

Also in 2016, among adults age 18 and older, 14.4% received some form of mental healthcare over the previous year. This percentage was measured by responses to questions about whether respondents sought help for their "nerves," anxiety, or their emotions. For the purpose of the survey, the category of *any mental illness* was defined as a "mental, behavioral, or emotional disorder" that can range from no impairment to mild, moderate, or severe impairment (National Institute of Mental Health, 2017). For adults with any mental illness, 43.1% received treatment services in the past year. *Serious mental illness* was defined as the same "mental, behavioral, or emotional disorder" but has a major impact on one's life that causes serious functional impairment (National Institute of Mental Health, 2017). Examples of serious mental illness include schizophrenia and bipolar disorder. For those adults with serious mental illness, 64.8% received mental health services in the past year (SAMHSA, 2017).

It is very difficult to generalize about mental healthcare because access to services varies widely by state. For example, the highest rates of access to care are found in Vermont, Massachusetts, Maine, Connecticut, and Minnesota (Nguyen & Davis, 2018). The states with the lowest rates of access to mental healthcare and the highest rates of incarceration are among the poorest: Alabama, Arkansas, and Mississippi (Nguyen & Davis, 2018).

Lack of health insurance can directly limit access to mental healthcare. Those persons with private insurance or those with the ability to pay on their own have significantly greater access to mental health resources. The poor have less access to mental healthcare and may receive lower-quality mental healthcare services. One's health insurance status can be related to one's level of stress. In the Stress in America survey conducted in 2017 for the American Psychological Association, 43% of respondents indicated that healthcare concerns were a source of stress and 66% reported that health insurance costs were also a source of stress (American Psychological Association, 2018). Further, having public insurance such as Medicaid can be associated with higher levels of anxiety (Jacobs, Hill, & Burdette, 2015). Not surprisingly, adults without

health insurance reported higher levels of overall stress than those adults with health insurance (American Psychological Association, 2018).

Class disparities have significant effects on mental health. The poor and disadvantaged groups live with more stress and problems associated with mental health issues, including gun violence, obesity, smoking, and other health issues (Schroeder, 2016). Chapter 7, Gender, Race, Ethnicity, and the Mental Health System, and Chapter 8, Social Work, Mental Illness, and the Criminal Justice System, discuss class disparities in terms of access to healthcare and the greater likelihood of the poor and minorities having contact with the criminal justice system.

STIGMA AND MENTAL ILLNESS

Often it is the lack of knowledge and understanding of mental illness that is associated with the assignment of stigma to individuals with mental health problems (Rusch, Angermeyer, & Corrigan, 2005). In fact, in many cultures, mental illness is among the most stigmatized conditions. Stigma is based on *stereotypes*—that is, beliefs about certain groups within a society (Corrigan & Shapiro, 2010). *Prejudice* is the negative attitude toward those groups, and *discrimination* is the behavior that results from prejudice (Corrigan & Shapiro, 2010). Prejudice and stereotyping are not sufficient in and of themselves to stigmatize. Instead, stigma is the actual discrimination based upon power differentials (Rusch et al., 2005). It can take the form of discrimination directed toward individuals with mental illness as well as institutional discrimination that, whether intentional or not, reduces life opportunities for those with mental illness (Rusch et al., 2005). It is the structural discrimination toward the mentally ill in American society that results in both the lack of and the poor quality of mental health services (Schulze & Angermeyer, 2003).

So powerful is the stigma of mental illness that it reduces the chances that those with mental illness will seek help. For affected individuals, this can mean missed opportunities for appropriate treatment. In addition, the stigma of mental illness exacerbates the problems associated with determining its prevalence (Baumann, 2007; Jackowska, 2009; Rusch et al., 2005). In some cases, persons with mental disorders may have their physical health problems overlooked by health professionals, with their physical symptoms being erroneously attributed to their mental illness (Thornicroft, Rose, & Kassam, 2007).

Severe mental illness such as schizophrenia can bring rejection to individuals and their families from others and also from mental health professionals themselves (Jackowska, 2009). One survey of people with schizophrenia in Poland found that 58% expected discrimination in their contacts with other people and 50% expected stigma in employment (Cechnicki, Angermeyer, & Bielanska, 2011). Higher levels of

perceived stigma by those with schizophrenia can be linked with low self-esteem (Berge & Ranney, 2005).

In a study comparing individuals with bipolar disorder and those with depression, both groups reported that they felt stigmatized. However, those with bipolar disorder felt an even greater psychosocial impact (Lazowski, Koller, Stuart, & Milev, 2012). Another study found that when respondents in the United Kingdom focused on the biomedical causation of bipolar disorder, there was increased compassion and less desire to maintain social distance (Ellison, Mason, & Scior, 2015).

It is hard enough for persons with mental illness to cope with symptoms and behaviors, but stigma adds another layer of stress (Rusch et al., 2005). These effects of stigma can last for many years and even a lifetime. *Self-stigma* is defined as the mentally ill taking on the stigmatized attitudes toward themselves. Internalizing the stigma associated with mental illness can lead to lower self-esteem (Corrigan, Kerr, & Knudsen, 2005; Corrigan & Rao, 2012). Self-stigma can also extend to negative beliefs about one's own character and competency. It fosters negative emotional reactions to the self and results in behavior that restricts opportunities (Corrigan et al., 2005). Perceptions of stigma by those with mental illness can be associated with an overall lower quality of life, including restricted social connections and fewer work opportunities (Alonso et al., 2009; Corrigan et al., 2005).

An individual's choice to disclose mental illness can be empowering and inspiring or, alternatively, negative and self-deprecating, depending on the circumstances (Rusch et al., 2005). Programs to promote self-empowerment may include feeling a sense of control over one's life and treatment, which are discussed in Chapter 11, Innovations in Mental Healthcare, and Chapter 12, Prevention and Future Issues in Mental Health Social Work (Corrigan et al., 2005; Corrigan & Rao, 2012).

Mental health professionals themselves can hold stigmatizing attitudes, most commonly directed toward individuals with schizophrenia (Nordt, Rossler, & Lauber, 2006; Rusch et al., 2005; Schulze & Angermeyer, 2003). As we will learn, some mental health professionals are not willing to serve the most serious mentally ill and drop participation in the Medicaid program (Corrigan et al., 2005). The fact that some psychiatrists can hold the same negative attitudes toward the mentally ill calls into question whether psychiatrists are appropriate role models in antistigma efforts (Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004).

THE MEDIA AND MENTAL ILLNESS

It is common knowledge that the media play to stereotypes of the mentally ill as unpredictable and dangerous (Angermeyer & Schulze, 2001; Ma, 2017). Indeed, when heinous crimes are committed and reported in

news outlets, there is always some question as to whether the perpetrator has a history of mental illness. Invariably, someone makes the point that "normal" people do not commit heinous crimes and, therefore, the perpetrator must be mentally ill. When few people have knowledge of mental illness, it is not a surprise that most rely on images from the news, television, and movies. News outlets engage in selective reporting, which then influences the public to believe mental illness should be stigmatized and is a cause of violent crime (Angermeyer & Schulze, 2001). In truth, those persons with mental illness are not more likely to be dangerous than individuals without mental illness (Rueve & Welton, 2008). This issue is explored further in Chapter 8, Social Work, Mental Illness, and the Criminal Justice System.

The association of violent crime with mental illness by the media is not accurate, and more realistic portrayals in the media can reduce the stigma. One study of college students found that almost one fourth obtained their perceptions of mental illness from television and films and were also more likely to think of these as realistic portrayals (Aguiniga, Madden, & Zellman, 2016). Research shows that nonstigmatizing messages about the mentally ill can influence the public to be more supportive of increased funding and services (McGinty, Goldman, Pescosolido, & Barry, 2018).

Evidence-based methods to reduce stigma include working to counteract the negative effects of advertising and media reports about mental illness (Rusch et al., 2005). Education aimed at providing factual knowledge about mental health is known to be more effective among those who start with a strong knowledge base. Research shows that personal contact with the mentally ill has positive effects on attitudes (Rubio-Valera et al., 2016; Rusch et al., 2005). Other suggestions include providing information to address causal beliefs about mental illness (Ellison et al., 2015). See Tips for the Field 1.2 for a list of suggestions for how social workers can help to reduce the stigma of mental illness.

TIPS FOR THE FIELD 1.2

DIGGING DEEPER INTO MENTAL HEALTH STIGMA: WHAT SOCIAL WORKERS CAN DO

1. Social workers can evaluate their own attitudes toward those with mental illness and work to reduce their own stigmatizing attitudes.
2. BA and MSW degree programs can offer more courses on and opportunities to learn about mental illness and infuse mental health issues into the curricula. Academic programs can also increase the availability of field instruction and internships in mental hospitals and outpatient clinics.

3. Social workers can help reduce stigma by working with and supporting family members. This will enable family members to receive the support they need and reduce the stigma felt by family members themselves.
4. Social workers can develop and lead antistigma programs and workshops that challenge misconceptions about mental illness. These programs and workshops can be offered to the general public, to family members, to police and other law enforcement agencies, and to other mental health professionals.
5. Social workers can advocate for change within their own agencies, ensuring that the needs of the mentally ill are a priority within the scope of service.
6. Social workers can advocate for policy change by providing education to legislators and other policy makers and by positioning themselves to contribute to policy development.
7. Social workers can design and carry out research studies that assess stigma and help to enhance the knowledge base regarding stigma.

SOURCES: Ahmedani, B. K. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values and Ethics, 8*(2), 4–16; Rubio-Valera, M., Aznar-Lou, I., Vives-Collet, M., Fernandez, A., Gil-Girbau, M., & Serrano-Blanco, A. (2016). Reducing the mental health-related stigma of social work students: A cluster RCT. *Research on Social Work Practice, 28*(2), 164–172. doi:10.1177/1049731516641492

WHO IS AFFECTED BY MENTAL ILLNESS? PRESIDENT TRUMP AND THE GOLDWATER RULE

Exactly who gets mental illness? There is much debate about how mental illness develops. Is it biological? Is the home life, the community environment, or even a traumatic brain injury that results in mental illness to blame? Is it a combination of these factors? Psychiatrist Thomas Szasz characterized mental illness as simply "problems in living," rather than a disease process (Szasz, 1961). Explanations for mental illness have continued to evolve through the years and are discussed in Chapter 2, A Short History of Mental Health Policy and Treatment in the United States. More recently, WHO (2018b, 2018c) has found that mental health problems can result from human rights violations, crime victimization, financial pressures, gender discrimination, difficult or inadequate employment, social isolation, physical health problems, and genetic predisposition. We will learn in this text that psychiatrists, social workers, psychologists, and mental health counselors do not necessarily agree on how mental illness develops or how to diagnosis and treat the different forms of mental illness.

Even the president of the United States has been the subject of media coverage regarding whether he has a mental disorder. Much controversy

exists among the public as well as some mental health professionals regarding the mental health of President Donald Trump (Lee et al., 2017). He has been called "narcissistic," a term that has been extensively discussed by the media (Scharfenberg, 2017). This issue has garnered so much attention that *The Boston Globe* printed a front-page article in February 2017 as Trump began his presidency. *The Boston Globe* staff conducted interviews with 10 psychiatrists and psychologists, some of whom supported Trump and some of whom did not (Begley, 2017). All 10 respondents agreed that Trump has a need to feel superior to other people. However, to warrant a diagnosis of mental illness—in this specific case, narcissistic personality disorder—as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, the individual must suffer some distress and some level of impairment. In the case of President Trump, he does not appear to display distress, and his behavior has brought financial success and media attention in the business world that served as his stepping-stone to the presidency. In contrast, some political pundits have focused on Trump's business failures that have been downplayed over time and that have resulted in him declaring bankruptcy several times.

As a result of the election of Donald Trump to the presidency, there has been a resurgence of discussion about what is known as the Goldwater Rule. This ethical rule stems from a 1964 survey by *Fact* magazine of 12,356 psychiatrists about whether presidential candidate Barry Goldwater was psychologically fit to serve as president of the United States (Levin, 2016). Responses included that he was a "paranoid schizophrenic," suffering from a "chronic psychosis," and "a megalomaniacal, grandiose omnipotence" (Levin, 2016, pp. 1–2). It appeared that some psychiatrist respondents were taking issue with Goldwater's very conservative politics rather than rendering a true picture of the mental health of the candidate himself. This controversy over the mental health status of a political candidate in 1973 led to what is now known as the Goldwater Rule: Section 7.3 of the American Psychiatric Association's (APA) *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* explicitly states that while psychiatrists can share their general expertise, it is unethical to offer a professional opinion unless a psychiatrist has examined an individual and has received that specific individual's permission to make that assessment public (Mayer, 2010).

In March 2017, there was further interpretation of the Goldwater Rule by the APA that psychiatrists cannot and should not diagnose from afar and, further, cannot make any comment on a public figure's "expressed emotion, speech or behavior, even in an emergency" (Lee, Glass, & Fisher, 2018, p. 10). The authors of the controversial 2017 book *The Dangerous Case of Donald Trump* clarify that they were not seeking a diagnosis for President Trump but rather were sounding an alarm about

"the dangers of Trump's proximity to weapons of mass destruction" (Lee et al., 2018, p. A10). The authors describe their efforts as a "duty to warn," rather than an effort to formulate a mental health diagnosis.

Regardless of where one stands on the Trump presidency, there are indicators that stress has increased among Americans since his election. The Stress in America survey conducted in 2017 by the American Psychological Association (2018) found that 63% of respondents felt stress over "the future of our nation." Mental health professionals have also reported increases in stress and anxiety attributable to concerns about the future of the United States, leading more people to seek psychotherapy (Arnett, 2017).

CURRENT STATUS OF THE MENTAL HEALTH SYSTEM

Overall, no cohesive national mental health system exists in the United States. Those in need of mental healthcare can face barriers due to lack of insurance or private funds to pay. A 2009 assessment of the mental health system in the United States by the Congressional Research Service, the public policy research division of Congress, found "evidence suggests a comprehensive transformation of the mental health system could be necessary" (Sundararaman, 2009). Recommendations from the report included (a) providing evidence-based practices, (b) increasing the mental health workforce, (c) ensuring access to mental healthcare, (d) increasing professional coordination and collaboration, and (e) improving research evaluation of treatment services. These recommendations have largely gone unnoticed and disregarded, with the result being that no comprehensive systemic delivery of service has been developed. More recently, in 2015 the SAMHSA offered a plan to improve mental health in the United States. See Tips for the Field 1.3 for the SAMHSA recommendations.

TIPS FOR THE FIELD 1.3

THE PLAN OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION TO IMPROVE MENTAL HEALTH IN THE UNITED STATES

1. *Increase prevention, treatment, and recovery services.* This includes early intervention and integrated treatment to prevent more expensive mental healthcare and to move toward providing services comparable to those that would be provided to individuals with other health conditions. This recommendation aligns with the core competencies of the CSWE) to assess (number 7 in Tips for the Field 1.1) and intervene with individuals, families, and groups (number 8 in Tips for the Field 1.1).

2. *Expand the mental health workforce*. The shortage of mental health professionals must be addressed, and new professionals must be culturally competent and trauma informed. Much more financial and other kinds of investments must be made to ensure the availability of innovative treatment approaches that include crisis prevention, medication management, intervention strategies, community resources, and family and peer supports.
3. *Widen the use of information technology*. Technology can be effectively utilized to fill in the gaps with hard-to-reach groups such as those living in rural areas. For example, these technologies can include telepsychiatry and online psychotherapy. Electronic medical records can help ensure that all medical professionals have access to a client's medical history and problem list. Technology can also bolster the clinical skills of mental health professionals by giving them access to a wide variety of educational and training opportunities such as webinars.
4. *Educate the public*. The stigma of mental illness has long been acknowledged as holding back the development of innovations in treatment. Negative attitudes toward the mentally ill contribute to the lack of medical and social attention to this group, and stigma often prevents those with mental illness from seeking help. Awareness strategies and campaigns need to be mounted in academic environments, workplaces, and faith communities to reduce prejudice.
5. *Invest in research*. Much more needs to be known about genetic predisposition and brain development and their impact on an individual's mental health. We need to further distinguish the types of mental illness and their corresponding best treatments.

SOURCE: Hyde, P. S., & Del Vecchio, P. (2015, February 18). *Five point plan to improve the nation's mental health*. Retrieved from https://blog.samhsa.gov/2015/02/18/five-point-plan-to-improve-the-nations-mental-health

SOCIAL WORKERS IN MENTAL HEALTH

Social workers are the largest group of professional providers of mental health services in the United States. Social workers are uniquely qualified to develop and improve policy and practice. The beginnings of the social work profession included the development of societal responses to mental illness, especially individual treatment for mental disorders (Social Work Policy Institute, 2004).

Mental health social workers must contend with the context in which services are provided, which encompasses legal, policy, political, and social issues (Sawyer et al., 2016). Typically, social workers are not perceived to be those who implement mental health policy. To change this perception, they must strive to develop and expand their expertise and power in the arena of mental health policy. Social workers must influence and work directly with legislators and other policy developers (Powell, Garrow, Woodford, & Perron, 2013), which may mean improving existing policy as well

as developing new policy. Social workers can also support their clients by participating in formal policy development. They may develop informal policy by creating specific treatment and referral collaborations with other agencies to ensure continuity of care (Powell et al., 2013).

Since a variety of mental health specialists provide mental healthcare services, there can be controversy over who is best trained and who is in the best position to provide these services (Sawyer et al., 2016). In reality, much remains to be done to develop a continuum of mental health services, and there is room for all kinds of mental health practitioners. Today psychiatrists are often called psychopharmacologists because their practices focus on prescribing medications to treat mental illness rather than providing psychotherapy. Psychologists have the expertise to provide psychological testing that can assist in determining proper diagnoses and also provide psychotherapy. Mental health counselors provide individual and group counseling to clients who have mental illness. Psychiatric nurses are able to prescribe psychotropic medications in some states and also provide psychotherapy.

Social workers have a wide range of expertise, including clinical evaluation, treatment skills, and supervisory skills within agencies. In addition, they can take up the mantle of leadership in the field of mental health, as discussed in Chapter 12, Prevention and Future Issues in Mental Health Social Work. Social workers keep current on the availability of community resources and understand how to circumvent the bureaucratic rules that control access to services. They promote self-advocacy for their clients. They know the importance of strong and supportive families and communities. Social workers understand the relationship between climate change and mental health as they advocate for environmental justice (Anderson & Jane-Llopis, 2011; Jackson, 2018). A core competency as established by CSWE (number 3 in Tips for the Field 1.1) is to advance human rights, as well as social, economic, and environmental justice. See Tips for the Field 1.4 for the principles that guide the provision of mental health services by social workers.

TIPS FOR THE FIELD 1.4

PRINCIPLES OF THE COUNCIL ON SOCIAL WORK EDUCATION TO DIRECT THE PROVISION OF MENTAL HEALTH SERVICES BY SOCIAL WORKERS

The CSWE devised the following principles to guide the role of social work in mental health and behavioral healthcare:

1. *Meet the needs of the individual.* This includes an individual's access to mental healthcare, diagnosis, treatment including medication management, and additional

supportive resources. The CSWE supports the provision of these services by licensed MSWs and states that mental health service provision should not be restricted to those professionals with MDs (psychiatrists or other physicians) and those with PhDs (psychologists). Additionally, the CSWE seeks to ensure that peer-based services are provided by those who have experience, adequate training, and appropriate supervision.

2. *Recognize social determinants of health*. Social determinants of health are circumstances under which individuals are born, develop physically and mentally, live and work, and become older adults. These experiences are shaped by the distribution of power and money at all societal levels. The CSWE supports services that will address the social determinants as they impact the mentally ill.
3. *Support a team-based approach*. Collaboration with other social workers and other mental health professionals is the best way to ensure the highest quality of care. This includes psychiatrists, primary care physicians, nurses, psychologists, and mental health counselors. All can benefit from educational programs designed for the mental health professions. There is also the need to increase the number of mental health professionals in the United States. For example, the CSWE supports initiatives to develop and expand health training programs such as the Minority Fellowship Program of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Mental and Behavioral Health Education Program at Health Resources and Services Administration (HRSA), and the Behavioral Health Workforce Education and Training Program, a collaboration between SAMHSA and HRSA.
4. *Recognize the value of social workers*. Social workers should not only provide clinical and supervisory services, but also be involved in policy. This includes serving in advisory and consultative roles to organizational leadership and committee participation.

SOURCE: Council on Social Work Education. (2014, October). *The role of social work in mental and behavioral health care: Principles for public policy*. Alexandria, VA: Author. Retrieved from https://www.cswe.org/getattachment/Advocacy-Policy/RoleofSWinMentalandBehavorialHealthCare-January2015-FINAL.pdf.aspx

Now is the ideal time for more social workers to consider a specialty in mental health treatment and policy. In the coming years, the federal government, through SAMHSA, is making serious mental illness a priority on the national level (Pace, 2017a, 2017b). However, because an inadequate number of all mental health professionals exist, expanding the assessment and treatment skills of social workers will make significant contributions to the field. Additionally, regarding policy, the NASW recommends offering more policy-type field placements in social work programs to cultivate greater knowledge of policy among social workers and to cultivate a link between policy and social work interventions (Pace, 2017b).

SUMMARY AND CONCLUSION

A great deal must be done to improve the quality and access to mental health services on international and national levels. Research on global mental health interventions must be expanded to determine the most appropriate types of treatment. As the largest providers of mental healthcare in the United States, social workers are well qualified to provide these services. The stigma of mental illness has long interfered with help seeking by individuals and their families. Efforts to reduce stigma by social workers can have a positive effect on improving the societal response to mental illness. Together, the CSWE principles and the SAMHSA plan have important contributions to make to improving quality and access to mental healthcare in the United States.

DISCUSSION QUESTIONS/TOPICS

1. Why is it difficult to define mental illness?
2. Discuss your ideas for how global mental health can be improved.
3. What social factors contribute to mental health problems?
4. How can the core competencies defined by the CSWE strengthen the American response to mental health problems?
5. What can be done so that the media offer more realistic portrayals of mental illness?
6. How should the media explore the potential mental health problems of a sitting president of the United States?
7. How can technology improve services for those with mental illness?
8. Discuss some of your own ideas for how social workers can help reduce the stigma of mental illness.
9. Discuss why there has not been much progress in the development of mental health policy in the United States.
10. How can federal agencies such as SAMHSA help to expand and improve mental health services?

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