REFLECTIONS ON THE FACE OF THE PERSON WITH MENTAL ILLNESS: AN AMERICAN PERSPECTIVE

REFLEXIONES SOBRE LA CARA DE LA PERSONA CON ENFERMEDAD MENTAL: UNA PERSPECTIVA ESTADOUNIDENSE

Rosemary Donley
Ph.D., APRN, FAAN, Professor of Nursing and the Jacques Laval Chair for Justice for Vulnerable Populations Duquesne University

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ABSTRACT

One in five adults and children in the United States experience some form of mental illness. Although there have been amazing developments in science, improved education of a cadre of mental health professionals, enhanced drug therapy, more public funding, and innovative trauma informed care, significant mental health disparities persist. Enduring myths about mental illness, separate but unequal physical and mental health delivery systems, lack of mental health parity in benefits, payments and access to health insurance, inadequate and un-coordinated community-based services, and an established mode of health delivery that values profit margins and rewards high technology medicine contribute to the burden of the person with mental illness. Poor individuals and families, members of minority groups, children in foster care, and persons who experience or witness violence are most at risk for mental disorders. These groups are untreated and lack access to the Social Determinants of Health. The great promise of the Community Mental Health Act of 1963 remains unfulfilled. Will the Affordable Care Act of 2010 and Medicaid expansion enable persons with mental disorders to obtain health insurance and find community-based delivery systems to help them cope with their treatable chronic disease? Good will is not enough. Social justice is an action theory. It invites us to stand in solidarity with the mentally oppressed and share their burdens. We are invited us to look into the faces of persons with mental illness with respect.

Key words: *Disparities, mental health parity, social determinants of health, trauma informed care.*

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RESUMEN

Uno de cada cinco adultos y niños en los Estados Unidos sufre algún tipo de enfermedad mental. Aunque se han producido avances asombrosos en la ciencia con la mejora de la educación de un grupo de profesionales de la salud mental, terapia de drogas mejorada, más fondos públicos y de atención de trauma innovadora, las disparidades significativas de salud mental persisten. Los mitos perdurables sobre las enfermedades mentales, los sistemas de salud física y mental separados pero desiguales, falta de paridad de salud mental en los beneficios, pagos y el acceso al seguro de salud, los servicios inadecuados y poco coordinados basados en la comunidad, y una vía reconocida de prestación de salud que los valores márgenes de beneficios y recompensas médicas de alta tecnología contribuyen a la carga de la persona con enfermedad mental. Los individuos y las familias pobres, los miembros de los grupos minoritarios, los niños en hogares y las personas que experimentan la

violencia o testigo de ella están en riesgo de trastornos mentales. Estos grupos son tratados y no tienen acceso a los Determinantes Sociales de la Salud. La gran promesa de la Ley de Salud Mental de la Comunidad de 1963 no se ha cumplido. ¿La Ley de Asistencia Asequible de 2010 y la expansión de Medicaid de las personas con trastornos mentales para obtener un seguro de salud y encontrar sistemas de entrega basados en la comunidad para ayudar a hacer frente a su enfermedad crónica tratable? La buena voluntad no es suficiente. La justicia social es una teoría de la acción. Nos invita a ser solidarios con los oprimidos mentales y compartir sus cargas. Los invitamos a mirar con respeto la cara de las personas con enfermedad mental.

Palabras clave: *Desigualdades, paridad de salud mental, determinantes sociales de la salud, cuidado informado del trauma.*

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INTRODUCTION

Although mental disorders know no geographic or temporal boundaries, this chapter will discuss scientific developments in the field of mental illness, changes in policy and practice and their impact on persons with mental disorders over the past half century in the United States. It will also identify and make explicit some strategies to improve care of persons with mental disorders.

In 1963 The Community Mental Health Act became public law. Today, mental illness remains a health disparity fueled by shame, denial, delays in seeking diagnosis and treatment, and an almost invisible mental health care system. Individual and family responses to mental disorders are intensified by difficulties in navigating hidden mental health networks; access is delayed by lack of money, no or inadequate health insurance and the geographic maldistribution of competent mental health specialists. In the United States, mental health services exist as a separate but unequal health care delivery and financing system, grounded in capitalism and organized around a false dichotomy between mind and body.

The separation of the physical and mental health services limits access and continuity of care. Many persons with mental illness seek relief in alcohol or drugs. These self-care remedies complicate their lives, worsen their co-morbidities and deepen their social isolation. Persons with mental illness are disproportionately represented on lists of Medicaid and Welfare recipients; many find themselves living in shelters, under bridges or in prisons[1]. Unlike other developed countries, the United States lacks a just and compassionate program of care for persons with mental illness.

This insight is tragic because in the 21st century, mental illness is a treatable chronic disease. The passage of the Affordable Care Act of 2004 provides another opportunity for the public and the health establishment to create quality mental health services and provide parity in mental health benefits and payments. Action on behalf of persons with mental disorders challenges our imagination, our resource allocation and our sense of justice. Recognized as the leading cause of disability in the world, mental illness manifests itself in all races and genders, across all educational and income levels, and among all religious groups[2]. Across a spectrum of severity, biologically-based brain disorders affect thinking, feeling, mood, relational abilities and the capacity to cope with the demands of life[2].

According to the World Health Organization (WHO), mental disorders affect about 450 million people around the world, one in four persons and 20 percent of

the world's children[3, 4]. Because of its prevalence, it is not surprising that mental illness has many expressions: symptoms of mental illness accompany serious acute and chronic illness; and mental illness is linked to substance abuse[5].

Evidence of the complexity of mental health disorders is also reflected in its classification system. In 1978, the World Health Organization's ICD- 9 identified 17,000 codes for various mental health disorders; in 2014, the revised ICD-10 listed 150,000 codes[5].

More significant than the number of people burdened by mental illness or the increased number of categories in the diagnostic coding system is the evidence that nearly two-thirds of persons with identifiable mental disorders do not seek treatment[3]. This finding is tragic because mental illness is treatable and, like most chronic disorders, responds to early identification, intervention, and care coordination[6].

WHO[7] names five key barriers to treatment: 1) the absence of mental health from the Public Health agenda, 2) limited funding and resource allocation especially in the ratio of properly educated physicians and nurses to the population, 3) the organization of mental health services, 4) incomplete integration of primary and mental health care along with 5) leadership failures. With planning, organization and adequate resource allocation, these barriers can be overcome[8, 9].

In its listing of facts about mental illness, the WHO[7] notes disparities among low and middle income and affluent countries. Low and middle income countries experience more mental disorders yet provide fewer resources for mental health services. Not surprisingly in these low and middle income countries, sudden death by suicide is a common outcome of mental illness; 75% of global suicides occur in lower and middle income countries[10]. In the United States, a wealthy nation, suicide is the tenth leading cause of death[11]. In 2013, 41,149 individuals in the United States died from suicide (13.02/10,000[12]; more than half of these deaths (6.7/10,000) resulted from self-inflicted gunshot wounds[12]. Anestis and Anestis[13], in their examination of the impact of state laws limiting possession of handguns, observed that strict handgun laws are associated with lower suicide rates in the United States.

Although suicide occurs throughout the life cycle and increases with advancing age, suicide is the third leading cause of death among people, ages 10-24[14]. More common among men, the typical American who completes suicide is a depressed 45 year old man who is an alcoholic[15]. However, there is more to the epidemiology of mental illness than access to guns and alcohol use. The long war in the Middle East has increased the rates of depression, post-traumatic stress disorders and cognitive injuries[16]. Military suicide attempts among members of the U.S. Army during the wars in Afghanistan and Iraq have increased[17]. Recent (2015) data from the Department of Defense showed a declining suicide rate in 2013 when all members of the active-duty force were compared to a matched sample of civilian men of similar socio-economic standing. However, the number of suicides among the National Guard and Reserve populations increased. Their rates of suicide remain significantly higher than those of their civilian counterparts[18].

Mental illness is more common in the United States than many people think[19]. Although it is not a leading cause of death, about 20% of Americans suffer from diagnosable mental disorders, 1 in 5 people over 18. Mental illnesses, major depressions, bipolar disorders, schizophrenia and obsessive compulsive disorders, account for four of the ten leading causes of disability among Americans[20]. Specifically, 1.1% of adults live with schizophrenia. 2.6 % have a bipolar disorder, 6.9% of adults had at least one major experience of depression in the past year, and 18.1% have anxiety disorders, such as posttraumatic stress disorders, obsessive-compulsive disorders and/or specific phobias[19].

Among the 20.2 million adults in the USA, who experienced substance use disorders, 50.5% (10.2 million) have co-occurring mental illness[20]. In 2011, mood disorders were the sixth principal diagnosis of persons discharged from American hospitals (29/10,000)[21], striking young people between the ages of 16-25 as they enter the most productive years of their lives. Mental illness costs the American people about $193.2 million dollars in lost earnings each year[14].

The care and treatment of persons with mental illness changed dramatically in the United States during the last century[22]. Like most paradigm shifts, the causes of this transformation in care were multidimensional: scientific advances, new theoretical explanations of the causality of mental disorders, evidence-based education of doctors and nurses, evidenced-based practice and team science, expanded treatment modalities for individuals, families and groups, drug breakthroughs, increased public awareness and advocacy for funding of therapy, earlier identification of mental disorders by the educational, medical and nursing professions, and some lessening of the stigma surrounding mental disorders and their behavioral manifestations[22, 23].

Several social movements have also shaped the mental health field and the care of Americans with mental disorders: community mental health, evidence-based mental health practice, and an evolving mental health policy framework.

Transitioning mental health care from institutions to communities

In 1965, persons with severe mental illness were transferred from large state-run mental hospitals and relocated to their local communities. This de-institutionalization process followed several national studies and the therapeutic introduction of Chlorpromazine (Thorazine). De-institutionalization was humanly and statistically dramatic. In 1994, 92% of the people who would have been living in mental hospitals in 1955 were residing in the community[24].

Today, persons with mental illness live in American cities and towns rather than state- run, public institutions[25]. However, some persons with mental illness are in institutions. Homeless shelters, prisons, jails and juvenile detention centers are the new mental hospitals[26]. The Treatment Advocacy Center showed in their recent survey of states that more persons with mental illness were in jails and prisons than in hospitals[15]. For example, Cook County jail outside of Chicago, Illinois is America's largest mental hospital; one third of the persons incarcerated there suffers from mental disorders[27]. Two other large institutionally-based mental health centers are jails in Los Angeles and New York City. These "new mental hospitals" lack an adequate number of trained physicians, nurses and mental health staff, adequate funding and the capacity to address the complex needs and symptoms of persons who reside within their walls, some of whom are burdened with serious mental disorders.

How did de-institutionalization come about? Specifically, de-institutionalization of persons with mental illness is the outcome of the Community Mental Health Act of 1963. Although President Kennedy had personal knowledge of the impact of institutionalization on the person with a mental illness and the family, his advocacy was congruent with and supported by the science and the sentiments of the day. As early at the mid-nineteen fifties, mental health professionals and ordinary people were losing faith in the value of long-term institutional care of persons with mental illness.

The public as well as the medical/nursing community also questioned the effectiveness of the dominant therapy, psychoanalysis, and the theories that supported it. Clinicians and researchers searched for new theoretical frameworks and treatment modalities[28]. Since then, each decade has brought amazing scientific breakthroughs

that support clinicians in their understanding of the etiology of mental illness and inform their treatment strategies. Contemporary mental health practice relies on knowledge gleaned from the social sciences, genetics, insight into the complexities of the central nervous system and its neural hormones, new drugs that alter biological pathways in the central nervous system, and evidence supportive of diverse therapeutic modalities: behavioral, cognitive, gestalt, humanistic, and pharmacological[29]. Mental health therapists integrate therapy, often talk therapy, with medication designed to help individuals, families or groups. Other mental health providers rely almost entirely on pharmacotherapy to control or reduce symptoms of mental disorders[30, 31].

Although the Community Mental Health Act was praised as the solution to the plight of persons with mental illness, its ambitious agenda and rapid implementation limited its success. Communities were unprepared and unwilling to accept into their neighborhoods persons who had lived for years in psychiatric institutions[27, 32]. Erving Goffman (1996) graphically described the personal impact of total institutionalization, likening spending many years in a mental hospital to living in a totalitarian social system[33]. As noted, in the period that followed de-institutionalization, there were not enough trained therapists, community mental health centers (only half of those authorized in the Community Mental Health Act of 1963 were built), public health agencies, community workers or emergency rooms to help persons with mental disorders as they transitioned into communities. It was easier to tear down psychiatric facilities than to build a community-based mental health system.

There were not adequate resources or compelling public interest in the plight of de-institutionalized persons with mental disorders, some of whom had lost the only world they knew. Many of the persons who were discharged from mental hospitals felt alone, without family members, friends, or social support. Ironically, although jails were not designed or oriented to treat persons with mental health disorders, it is said on the street that the only way to get treatment for mental disease today is to get arrested[24, 34].

The Mind-Body Dichotomy and its impact on mental health

Another obstacle to good mental health care is the separation between the health services offered for mental and physical disorders. Distinguishing between ills of the mind and ills of the body and providing separate services and systems for mental and physical health characterize traditional American medical practice and health care delivery and finance. Interestingly, mental health is not that visible on the public health agenda. The adoption of the critical importance of the Social Determinants of Health into Public Health may encourage public health professionals to discuss prevention of mental illness. The current mind-body dichotomy negatively affects mental health care and nurtures health disparities.

THE DOMINANT MEDICAL MODEL AND THE CARE OF PERSONS WITH MENTAL DISORDERS

The medical model is well entrenched in the American health system Both the health care and medical educational systems in the United States were built around a medical or disease-based model; as academic medicine developed, health institutions, especially academic health centers, became technological temples. The medical model was reinforced and validated by these technological advancements and by impressive financial investments from the private and public sectors. Money targeted to support bench science and stimulate the “cure” of heart disease, cancer and stroke, encouraged research, training and specialty and advanced practice within the medical and nursing communities[35, 36].

Today, the priority given to high technology medicine in the United States is reflected in: the prestige and financial rewards associated with high technology medical and nursing practices, the degree of specialization among physicians and nurses, the depth of specialty services provided in acute care hospitals, and reimbursement and private and public payments systems that stimulate and favor providers of medical/surgical services. Although there is strong rhetoric about the convenience and cost saving benefits of prevention and healthy life practices, ambulatory care and primary care, medically oriented service providers continue to restrict their neighborhood practices to persons with medical-surgical conditions. These practice patterns persist even when evidence shows the prevalence of anxiety disorders in patients in primary care settings[37-39]. Today, inter-professional collaboration and team-based practice support community based mental health care delivery.

The Affordable Care Act (ACA) encourages collaborative team based practice in community settings through Accountable Care Organizations (ACO) and Medical Homes. What is not known is if these organizations can effectively integrate physical and behavioral health services and pharmacological services for Medicaid enrollees because it is estimated that many of the 11 million new Medicaid enrollees have mental disorders[40].

Capitalism and care of persons with mental illness

Another distinguishing characteristic of the American health system is its contribution to the economy. Micro-economists study how markets, in this case health markets, coordinate de-centralized decision making through pricing mechanisms designed to bring supply and demand into equilibrium[41]. The health care industry contributes about 16.37 percent of the 16.768 trillion dollar accounted for in America's gross domestic product (GDP)[42]. Although identified populations, notably the aged, the permanently and totally disabled, and persons below the federal poverty line qualify for government health insurance, Medicare and Medicaid, employers have remained the main source of health insurance.

This feature of American health care is unique among wealthy nations in the world. It is well recognized that untreated or undertreated chronic illness interferes with gainful employment; lack of money is one of the major reasons why people do not receive mental health care. Persons with severe psychiatric disorders are more likely to be poor and have limited educational and employment opportunities[43]. Because the United States lacks government-sponsored health insurance for all its citizens, many persons with mental illness do not have health insurance and, as a consequence, have little access to mental health services on any consistent basis. Mental health care is not a lucrative business. It is well recognized that psychiatric emergency services are relatively unprofitable; emergency care is expensive. Even with mental health parity, inpatient psychiatric treatment is not as well reimbursed as medical and surgical conditions. Many hospitals that offer mental health services attract a poor, under insured, sick and sometimes difficult to manage population[44, 45].

These factors perpetuate a vicious cycle of poverty, lack of treatment, and diminished physical and mental health.

Health policy and economics

When health insurance was first introduced in the United States, it developed within the private sector. Offered as a work related benefit and directly linked to full-time employment, health insurance became an attractive component of compensation packages that industries used to attract and retain workers. Health insurance was a private not a public sector program; in America, it is not a right associated with citizenship. The original health insurance plans were designed and marketed to help workers and their families afford the costs asso-

ciated with admission to acute care hospitals and out-patient medical care. Typically, these early employer-sponsored health plans did not offer or pay for preventive services. When Medicare became public law in 1965, it was modeled on the extant private sector benefit and payment systems[46].

Interestingly, the benefit and payment methods designed for workers and their families shaped the new health insurance program for persons at or above the retirement age 65 and those unable to work because of severe or permanent disabilities. When Lyndon Johnson became President in 1964, Medicare and Medicaid, enacted as amendments XVIII and XVIX of the Social Security Act, became the centerpieces of the Great Society. The domestic programs of this era had as their main goals, the elimination of poverty and racial injustice. They addressed not only access to health care but gave opportunities for pre-school education, meals, and housing for poor families and children. Today, we recognize that programs like those featured during the Great Society are Social Determinants of Health[47].

Before the development of the Great Society's programs: Head Start, Food Stamps, Welfare, and Housing Subsidies, to name a few, many poor families could not afford pre-school education for their children or safe, adequate housing. Income assistance programs were limited, and it was not uncommon for children and elderly people to go to bed hungry. Although these programs did not benefit everyone, they made a difference in the lives and health status of poor children and poor elders.

As noted, Medicare became the most recognized and attractive of the Great Society programs because it was a federal not a state- run program that helped all aged and disabled Americans regardless of their socio-economic status or geographic locations. Although it can be argued that Social Security is the model for America's welfare programs, Medicare and Medicaid cannot be overlooked. These programs engaged the federal government directly in helping persons with mental illness obtain health insurance[48]. These persons benefitted greatly from this public sector engagement because prior to the passage of Medicare, the federal government was not involved in providing or paying for health care for persons with mental disorders. Each state designed its own program benefit and financing structures. At the time of the passage of Medicare, care of persons with mental illness had been a state responsibility for over 100 years[49].

THE GREAT SOCIETY

Although the Great Society movement made the federal government more involved in programs that helped the poor, the aged and the vulnerable, it did not establish a Welfare State like that developed in Germany during the 19th century or mimic the model that emerged in the United Kingdom in the early 20th century where citizenship guaranteed a right to health care, income support and other social services[50]. Medicare was restricted to persons who were aged and/or totally and permanently disabled; Medicaid, a state and federal program, had as its major constituents the poor elderly and poor mothers and children[51].

Other laws have kept mental health on the federal agenda since the passage of The Community Mental Health Act of 1963. New or expanded programs from the Great Society era provided research funds and educational training grants for mental health professionals, sparked innovative service delivery models and spawned new federal agencies to transform the mental health system[32]. The most recent federal law to add to the lexicon is The Affordable Care Act (2004). It encourages and provides funding for team-based, integrated primary care services based in local communities[52]. Medical Homes and Accountable Care Organizations are examples of new community delivery systems designed to integrate physical and mental health services, affirm

holistic care, and assure continuity of care for poor people[53].

Medicaid expansion may also increase access to community based care for persons with mental illness, especially those who frequent emergency rooms or use drugs and alcohol. Mechanic (2012) thinks that the newly expanded Medicaid programs will lead to better mental health services for all vulnerable people, especially individuals with mental illness [54]. However, as noted earlier in this article, the Accountable Care Organizations face many challenges. They will be challenged to re-integrate behavioral health services into their care systems. Many behavioral health services have been "carved out" and contracted to for profit and non-profit providers. These "carve outs" discourage holistic care and illustrate America's penchant for separating physical care from mental and emotional care.

Community Mental Health Revisited

Some fifty years after the passage of the Community Mental Health Act, mental health is once again on America's health agenda. There are advocacy groups and several federal agencies dedicated to promoting mental health. Mental health has been a special interest of first ladies, notably Betty Ford and Rosaline Carter. Congressional and Presidential actions define and clarify emerging mental health initiatives and assure funding for established programs, as Mental Health Centers and more recently Accountable Care Organizations and Medical Homes. At both state and federal levels, programs and funding are designed to assist certain populations, the aged, the poor, children, and persons who abuse drugs and alcohol. As the population in the United States ages, a new field, geriatric mental health, has emerged. The mental health of older Americans has been identified as a priority by the Healthy People 2010 and 2020[55, 56].

The 2005 White House Conference on Aging[57], and the 1999 Surgeon General's report on mental health[58]. Particular attention is also given to persons who abuse alcohol and drugs because of the established link between mental illness and substance abuse[59]. Returning veterans and others who suffer with post-traumatic stress disorders (PTSD) have joined the aged, children and persons with substance abuse disorders in attracting special federal interest and program support[60].

Support for mental health care is also included in appropriations and budget reconciliations laws. However, because of the American preference for curing diseases and the separation between physical and mental health delivery systems, health parity is difficult to achieve. In American establishing parity between and within mental and physical health systems remains an elusive goal[61].

Inadequate state funding also contributes to disparities in mental health funding and service delivery. Because mental health and treatment programs are included in state block grants and in Medicaid benefits and payment structures, mental health programs supported by state budgets are subject to political pressures and competing priorities and constituencies within each state.. Mental health program initiatives and Medicaid funds are often among the first programs to experience budget cuts. The National Alliance on Mental Illness (NAMI) described the impact across the United States of one such budget exercise, the 2011 federal budget cuts to the state- funded mental health programs. These reductions weakened the mental health safety net and limited mental health services to children, youths, adults and aged persons with mental disorders. The budget cuts did not spare emergency mental health services and other important programs such as: inpatient care, crisis intervention and stabilization teams, management services, community treatment programs, supportive housing and access to psychiatric medications. Projected cuts to the 2012 federal Medicaid funds were also projected by the NAMI staff[62].

Although mental health is on federal and state agendas, the voices of persons with mental illness may not be heard around policy tables when political deals are cut. People with mental illness do not advocate for themselves, contribute to political campaigns, attend re-election fund raisers, or lobby for more funding support for mental health initiative.

THE FACE OF PERSONS WITH MENTAL ILLNESS

Although many of the myths about people with mental illness have been dispelled, there remains an aura of mystery about mental illness and fear of persons with mental disorders. Media reports of the mental health status of serial killers or persons who shoot strangers in public places enhance these fears. Even if details of mass shootings are not revealed, it is easy to ignore, shun and even punish people who think and act outside social boundaries and norms. It is easier to build prisons that invest in robust prevention and treatment programs for persons with mental disorders.

While mental illness is treatable, the symptoms of mental illness are often masked or hidden. Many people deny their pain and burden because of fears of stigma and/or discrimination. Even in developed countries like the United States, mental illness, especially mental illness in children, is often undiagnosed and untreated[63].

The CDC, synthesizing the 2009 findings of the National Research Council and the Institute of Medicine, estimated that 13-20 percent of children living in the United States (1 out of 5 children) experience a mental disorder in any given year. They name: attention-deficit/hyperactivity disorders, behavioral disorders, mood and anxiety disorders, substance use disorders, and Tourette syndrome [64]. Poor children, minority children and children in the foster care systems are more at risk of mental disorders. They are also more likely to have experienced or witnessed assault, maltreatment and violence. Unrecognized or untreated, these traumatic experiences, especially if they occur early in the child's life or continue over time, can affect a child for the rest of his or her life[65].

Children in violent communities and war torn countries are also at high risk for post-traumatic stress, anxiety and depression[66]. The impact of traumatic events on the immediate and long term health of children is now recognized as a public health problem. Giving children the opportunity to discuss their experiences of trauma and violence during their routine assessment protocols raises the awareness of care givers and informs their care. When this information is revealed initially or over time, it should be entered into the data base so that the children can receive trauma-informed care[64].

THE FUTURE

What can be done in the United States to improve the lives of persons with mental disorders? Nurses, other health professionals and teachers can use relevant research findings and evidence to help dispel erroneous beliefs, allay public fears and lessen the stigma that surrounds persons with mental illness. They can advocate for the adoption of the Social Determinants of Health framework proposed by the National Academy of Medicine (2016) that encourages lifelong learning about the root causes that explain poor mental health[67]. Because risk factors for common mental disorders are highly associated with injustice: income inequities, poverty and the inability to achieve the public goods identified in the Social Determinants of Health, nurse researchers can disseminate what is known, seeking to clarify how these factors can be used to strengthen local communities. Social justice is an action theory. Beyond raising awareness, nurses can direct teams in the community to eliminate disparities in income, education, employment, zip codes and access to care and treatment for

those burdened with or at risk of mental disorders[68]. Standing in solidarity with the people most affected, nurses and health team members can become collaborators, working to increase the social capital that exists even in the poorest and most neglected communities[53]. In the political arena, nurses can form or join well-organized, socially-connected influence groups to lobby for mental health, promoting access to robust mental health plans, such as the one developed in 2013 by the World Health Organization[54].

CONCLUSION

Over 50 years ago, the community mental health movement was launched. Its expected outcomes are yet to be realized. Half a century later, we can offer persons with mental disorders, better science, experienced and well educated physicians, nurses and social workers trained in the application of effective treatment modalities and the use of pharmaceuticals. As encouraging, is the renewed public interest in mental health and a willingness to support sub-populations: children, the aged and returning members of the military with mental disorders. However, we cannot rest on what has been accomplished or hope for a more just or level playing field, we must build where we are. On the horizon is The Affordable Care Act. Although it has a different mission than Medicare, it offers persons with mental illness greater access to health insurance, especially those who live in states who have expanded their Medicaid programs. Unlike Medicare that provided institutionally-based and treatment oriented payment strategies for acute care hospitals, the Affordable Care Act supports outcome-oriented, holistic, community-based care. Accountable Care Organizations, Medical Homes and evidenced-based inter-professional team practices are the community-based care delivery models of the twenty-first century. The question to be asked by researchers, clinicians and teachers is will the new delivery system, the application of research findings and the experience gleaned over the past fifty years erode the stigma of mental illness, improve access to treatment, especially among children, the aged, the addicted, veterans and minority populations and lead to happier and healthier lives for the 20% of persons in the United States who are burdened with mental disorders?

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