山口医学　第50巻　第5号　741頁～748頁，2001年

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Psychiatric/Mental Health Care in the United States

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Key words：USA, Psychiatric/Mental Health, Nursing

Introduction

In America, mental health issues finally are beginning to be recognized and accepted as legitimate health care issues. There are estimates that over 60% of all hospitalized individuals experience some type of mental health problem. We know that over 20% of all Americans suffer from some form of mental illness during their lifetime. With the ever increasing stress that Americans experience, there appears to be a greater need for mental health care now than ever before.

Historical Background

Mental health care in America can be traced back to 1756, when the Pennsylvania Hospital in Philadelphia, was opened through the efforts of Benjamin Franklin and others for the purpose of providing treatment rather than only confinement of the mentally ill. Benjamin Rush, whose picture is reproduced on the seal of the American Psychiatric Association, has been called the "father of American psychiatry" due to his work at the Pennsylvania Hospital in the late 1700's and early 1800's. Due to a recognized need to provide moral treatment rather than mere confinement of the mentally disordered, the first American hospital, devoted exclusively to the care and treatment of psychiatric patients, opened in Williamsburg, Virginia in 1773.

In the early 1800's private psychiatric hospitals began to be built throughout the US. By the mid-1820's, however, it was recognized that these corporate hospitals could not meet all the needs of those requiring mental health services. Thus, the movement for public mental hospitals began. Sixty-two public psychiatric institutions were built across America by 1865. However, these very hospitals, which were built to treat the mentally ill, became an end in and of themselves. Moral treatment was replaced by custodial care. Once the individuals were removed from their stressful environment they got better, so it was believed that if you put the mentally ill in the institution, he or she would be "cured".

It was at the end of the 1800's that insanity was linked to faulty life habits and separate hospital facilities for the acutely mentally ill were advocated. This, also, was when new forms of physical therapy to treat the mentally ill were

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introduced, such as diet, massage, hydrotherapy, and electroshock therapy (ECT). ECT continues to be used in some hospitals, today, for the treatment of depression.

In the early 1900's, psychiatrists began to conduct research into the treatment of the mentally ill. Individuals, such as Alfred Adler, Carl Jung, Otto Rank, Karen Horney, and Anna Freud, practiced a new discipline called psychoanalysis. Many Americans found psychoanalysis intriguing and it often became a thing of status or importance among the rich and famous to have their own analyst. It was at this time that the cause of mental illness came to the forefront. Due to the number of psychiatric casualties (shell-shocks) America experienced during World War II the need for understanding mental illness was further expanded. Attention finally became directed toward mental and emotional disorders in America.

In 1955, "The Mental Health Study Act" was passed by the US Congress to set priorities and to define adequate services for psychiatric clients throughout America. It was determined, after a five-year investigation, that both the psychiatric resources and the network of mental hospitals throughout the US were not adequate to meet the needs of the mentally ill. Thus, the "Action for Mental Health" report, in 1961, was the first definitive plan on how to provide psychiatric services to those in need.

Prior to the 1960's, when President Kennedy was in office, mental health care truly was only *psychiatric* care. Almost all the individuals who experienced mental illness were treated via hospitalization. It was a "lock them up" and "get them out of society" mentality. Americans seemed to be afraid of the mentally ill and movies such as "One Flew Over the Cuckoo's Nest" did not help the image of the delivery of mental health care. The back wards of state hospitals were where the mentally ill were housed and medicated. Thorazine (chlorpromazine hydrochloride), an anti-psychotic medication, was the drug of choice. It was used to totally control the mentally ill. The mentally ill looked like and acted like "Zombie's". They often were overmedicated and too sedated to effectively interact. The staff provided food and water for the mentally ill, but delivered only limited therapeutic interaction.

President Kennedy, himself having a mentally ill sister, decided that the mentally ill needed to be "mainstreamed". In other words, treated like everyone else in society. He signed legislation in 1963 that created Community Mental Health Centers throughout the US. It was his desire for emphasis to be placed on primary prevention of mental illness and on implementation of care for the mentally ill in the community. The Community Mental Health Centers Act of 1963 made federal money available to states to plan, construct, and staff community mental health centers so that people could be treated in the community and to prevent hospitalization whenever possible. The Act also encouraged the formation of multidisciplinary treatment teams by combining the skills of many professions.

With the establishment of community mental health centers, deinstitutionalization became the mode of choice in dealing with the mentally ill. The mentally ill began to be released from the state owned psychiatric hospitals, some of which held as many as 5,000 patients. The US Court of Appeals mandated that the mentally ill be treated in the "least restrictive alternative to hospitalization".

Between 1963 and 1980, the number of individuals housed in state mental hospitals in America decreased by almost 75%, from 504,000 to 138,000. Many of the mentally ill literally were

turned onto the streets of America to survive, which lead to the mentally ill often being homeless. Even today, those who are homeless and live on the streets of America often suffer from some form of mental illness; usually either schizophrenia or dementia.

Fortunately, however, in order to address the needs of the mentally ill, the number and variety of mental health providers began to increase across America. Community-based psychiatric treatment often is provided, today, by public / private partnerships using grants and government funds, as well as by private enterprises and government agencies.

Mentally ill individuals who have been identified, evaluated, and treated in a public health care facility usually are assigned a case worker and are seen on a weekly, biweekly, or monthly basis for assessment of their mental illness and for medication regulation. Short-term intervention has become the treatment of choice, in addition to liberal usage of psychotropic medication (including anti-psychotics, anti-depressants and anziolytics). However, if an individual chooses not to take the prescribed medication or not to seek follow-up treatment, he/she can go through life as he/she chooses as long as he/she does not become identified as being a threat to himself/ herself or to others. The legal system, in America, can require involuntary hospitalization of a mentally ill individual if he or she is identified and assessed by a licensed mental health professional as being a threat to himself/herself or to others. Treatment of choice of the mentally ill, throughout the US, usually is through liberal use of psychoactive medication with or without mental health counseling. However, it must be pointed out that all individuals in America have freedom of choice. This is true for the providers, as well as for the mentally ill. Thus, in America, due to one's choice or to the choice of a provider who may want to become involved in the treatment of a particular person, an individual may or may not receive needed mental health care.

In regards to medications, it was in the 1960's that Americans began to pay attention to prescription medications. This was the time, both during and after the Vietnam War, when marijuana gained prominence and was being abused by a large portion of the population. This was when Americans learned that prescription medications could make you feel good. Everybody wanted to be free of personal anxieties. Relief was the desire and the pharmaceutical companies were pleased to oblige. When Valium (diazepam), a minor tranquilizer, became readily available as an effective anziolytic, Americans began to use it in increasing amounts. Valium probably was the first severely abused prescription medications in the US.

With the establishment of community mental health centers, drug treatment facilities also began to be opened in shopping centers. Mental health counseling became the "in thing" for bored, depressed, and anxious housewives. Women, in America have been and continue to be, the predominant users of health care. The stigma of mental illness slowly began, during the 1960's, to be removed. There still is a stigma about having a mental illness, but people now are more open about taking an anti-depressant, such as Prozac or one of the other Selective Serotonin Reuptake Inhibitors.

Americans also are more open about seeing a psychiatrist, psychologist, psychiatric social worker, psychiatric/mental health clinical nurse specialist, marriage and family therapist, licensed professional counselor, or pastoral counselor.

Types of Mental Health Providers

There are a variety of mental health providers in America who have a wide range of educational experiences and professional expertise. These include psychiatrists, psychologists, psychiatric social workers, psychiatric/mental health clinical nurse specialists, marriage and family therapists, licensed professional counselors, and pastoral counselors. The various mental health care providers may prescribe medications, admit mentally ill individuals to psychiatric hospitals, and/or provide individual, couple, marital, family, or group psychotherapy or counseling. These providers may specialize in treatment of adults and/or children. They may treat hospitalized patients and/or individuals on an outpatient basis. The educational background of each of these providers is dependent on the rigors of their chosen profession. Prior to conducting mental health care on their own, these providers may or may not have extensive clinical training and/or clinical supervision. Each of these professionals will be discussed.

Psychiatrists are physicians who have specialized in psychiatry. Educationally, they have received 4 years of college, 4 years of medical school, and at least 4 years of psychiatric residency prior to being licensed as a psychiatrist by the medical board in the state in which they work. They, as can all physicians in America, prescribe medications and treat patients in an office, clinic, or hospital setting. Psychiatrists may employ other mental health providers to provide counseling for the mentally ill or they work in collaboration with other mental health providers who are not their employees. In most psychiatric hospitals, in the US, the psychiatrist is considered to be the head of the mental health delivery team and, thus, ultimately responsible for the mental health care delivered. However, they usually do not do counseling to the same extent as other mental health providers. Psychiatrists have been viewed, by other mental health providers, as "the medicators" and "the admitters" of the mentally ill. They may be board certified by the American Psychiatric Association. Psychiatrists may work for the state or federal government, the military, an individual hospital or clinic, or have a private or group practice. Psychiatrists can easily earn $250,000 per year. Their income is limited only by the number of hours in the day and whether their fees have been limited by an insurance company or by a health maintenance organization.

A Psychologist is an individual who has a doctorate in psychology, as a clinical psychologist or as an applied psychologist. Prior to being licensed as a psychologist by the board of psychology of the state in which he or she desires to practice, a psychologist usually has completed 4 years of college, 2 years of masters education, and at least 4 years of doctoral study. A psychologist usually *cannot* prescribe medication or admit an individual to a hospital (this may change in the near future depending on the laws that are being passed by the various states). There is a movement, by psychologists in America, to gain prescriptive privileges and to achieve practice rights in psychiatric hospitals. Generally, psychologists only do counseling and/or psychological testing. Psychologists may work for a psychiatrist, a federal or state agency, a clinic, or in a group or private practice. They may or may not have other mental health providers working with or for them. If the psychologist is doing psychological testing, there may be a masters prepared psychologist who actually conducts the psychological testing while the doctorally prepared clinical psychologist makes the interpretation of the test results. A psychologist's income tends to be limited by the reimbursement scale set by the insurance companies and health maintenance organizations. However, a clinical psychologist may earn as

much as $150,000 a year.

A psychiatric social worker is an individual who has earned a masters degree in social work (after 4 years of college and two years of masters education) and has become licensed by the licensing board of the state in which he or she desires to practice. A psychiatric social worker may or may not be registered or certified by a particular board or agency, but is able to conduct mental health counseling and do resource and placement case work. Psychiatric social workers *cannot* prescribe medication nor conduct psychological testing. They are licensed only to do counseling and social work. Psychiatric social workers may be employed in a hospital, a nursing home, a state or federal agency, by a psychiatrist or a psychologist, or work in a group or private practice. Their income is limited due to the restrictions that have been placed on their fees by the insurance companies and the health maintenance organizations. However, a psychiatric social worker may earn up to $80,000 per year.

A psychiatric/mental health clinical nurse specialist is a baccalaureate prepared registered nurse who has a minimum of a two-year masters degree in psychiatric/mental health nursing. Although it is not necessary for a psychiatric / mental health clinical nurse specialist to have more than a masters degree in psychiatric nursing, many psychiatric/mental health clinical nurse specialists also have completed a four year doctoral program in nursing. A psychiatric / mental health clinical nurse specialist may become certified, via testing and number of hours of clinical supervision, as a psychiatric /mental health clinical nurse specialist by the American Nurses' Association and by the state in which he/she works. At present, in 47 of the states of the United States, psychiatric/mental health clinical nurse specialists *can* prescribe psychiatric medication, some independently of physicians and others only if they have a collaborative relationship with a physician. Psychiatric/mental health clinical nurse specialists do not admit patients to hospitals, but often have hospital privileges to evaluate and counsel patients who are hospitalized. If the psychiatric / mental health clinical nurse specialist has been certified, by the American Nurses' Association, he/she is entitled to reimbursement of services provided from the patient's insurance company. Psychiatric/mental health clinical nurse specialists may be employed by a hospital, a state or a federal agency, a clinic, other health care providers, such as family practice physicians and psychiatrists, or may work in a group or private practice. Their income is controlled in that their fees have been restricted by the insurance companies and health maintenance organizations. However, a psychiatric /mental health clinical nurse specialist can earn up to $150,000 annually.

There are three other types of mental health providers who are just beginning to become recognized and utilized in America. They are the Marriage and Family Therapists, the Licensed Professional Counselors, and the Pastoral Counselors. None of the individuals who have obtained these licenses within the US can prescribe medication, do psychological testing, or admit patients to a hospital. They only can conduct individual, couple, family, or group counseling. Perhaps the most recognized of this group are the Marriage and Family Therapists.

Marriage and Family Therapists first began to practice in California in the 1960's and have rapidly spread throughout the US. They are required to have at least two years of college and to be licensed by the Marriage and Family Therapist licensing board of the state in which they practice. Marriage and Family Therapist, predominantly, do marital and family counseling. Some of the states have begun to allow marriage

and family therapists to be reimbursed by the patient's insurance company or health maintenance organization. Many, however, rely on their patients paying cash for the counseling they have received. Most of the marriage and family therapists work in clinics or in a group or private practice. They often work for other health care providers. Marriage and family therapists income depends on whether they are insurance reimbursable or if they are employees of another provider. Those who are eligible for reimbursement from the patient's insurance company or health maintenance organization usually operate their own private practice.

Licensed Professional Counselors are growing in number. They have some educational courses in the college setting, but are not required to have a certain major. They have to pass a written test in order to be licensed by their respective state. Licensed Professional Counselors are beginning to be recognized by insurance companies as being eligible for reimbursement for the counseling they provide. Most work for other health care providers, thus their income is limited. Some, however, have begun to venture into private practice and are providing outpatient counseling services.

Pastoral Counselors have been around for some time, but, usually, have not been recognized as being anything more than pastors of churches. There is no specific educational requirement to become a pastoral counselor. All pastoral counselors are church pastors of various denominations. They may be Catholic, Baptist, Jewish, Lutheran, Methodist, or of some other religious denomination. They attend special classes and receive a certificate of course completion for having met a required number of hours of supervision. Most often, a pastoral counselor may be found providing counseling to the infirmed in a hospital setting or doing counseling as part of his or her pastoral duties. A pastoral counselor is what most people, in America, request as their counselor when they want a "Christian" Counselor. Pastoral Counselors are viewed as being spiritually connected. They are perceived as being more honest and less likely to tell someone to do something that may be against the individual's spiritual beliefs. Their income is dependent on what their church pays them and what their patients pay in cash. They are not insurance reimbursable.

Future of Mental Health Care

The increased emphasis on genetics in relationship to behavior and the increased knowledge about serotonin and norepinephrine has begun to change the delivery of psychiatric/mental health care. Today, there is an increased usage of psychoactive medications, especially in the treatment of depression, anxiety, and dementia. No longer does the physician immediately refer someone with emotional distress for counseling. Rather, the physician is likely to prescribe one of the SSRI anti-depressants or an anziolytic. Once the patient begins to feel better, he or she is not as likely to desire to talk about what has happened or to seek ways to cope with a similar situation in the future. Thus, mental health counselors are providing mental health care for healthier individuals who truly want to learn how to effectively cope with their problems.

Since the insurance companies and health maintenance organizations have begun to manage the mental health care patients are receiving, there has been a significant decrease in the utilization of mental health counselors over the past several years. No longer can a mental health provider see an individual as many times as he or she desires. Today the mental health provider has to justify the need for the patient to receive

mental health counseling. There has to be a plan of care and realistic objectives as to what the patient is to accomplish in therapy. Insurance companies and health maintenance organizations require mental health providers, who are being reimbursed, to submit an assessment of the patient so as to receive authorization to see the patient. After the insurance company or HMO approves the assessment and plan of action for therapy, they authorize a given number of sessions for the patient to be seen by the therapist. If more sessions are felt necessary, the mental health provider has to request, in writing, the number of sessions desired and the reason for wanting more sessions in which to treat the patient. There is constant monitoring of the mental health care the patient is receiving. It appears that such action has lead to a more informed patient who is more receptive to counseling and to mental health providers who are more aware of the need to evaluate the patient's progress and to justify the treatment modalities they are using.

Conclusions

The delivery of mental health care, in the USA, in the 21st century, is being provided by a variety of mental health providers who are better educated, more diverse in their treatment modalities, and are more informed regarding the mental health needs of the population they are serving. The American public, also, is less distressed about someone having a mental illness. Today, Americans are more likely to seek mental health care when needed. There has been a shift from hospitalization of the mentally ill to treatment as outpatients in the community. From sedation from medication, to utilization of natural brain chemistry elements that facilitate normal functioning of the individual. From psychoanalysis to true counseling in regards to how to cope with life.

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SUMMARY

This paper presents a historical overview of psychiatric/mental health care in the United States from 1756, when the Pennsylvania Hospital in Philadelphia, PA was opened to provide treatment rather than only confinement of the mentally ill, to the present day use of psychoactive medications and out-patient mental health counseling as the treatment of choice for those experiencing mental health issues. The various types of mental health providers that are delivering mental health services are reviewed. The emphasis on brain chemistry and genetics, in regards to mental health difficulties and treatment is presented. In addition, the effect that insurance companies and health maintenance organizations have had on mental health care delivery in America is discussed.