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# The Social Obligation to Reduce Stigma in Order to Increase Utilization of Mental Health Services

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THE SOCIAL OBLIGATION TO REDUCE STIGMA IN ORDER TO INCREASE  
UTILIZATION OF MENTAL HEALTH SERVICES

A Doctoral Project

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctor of Healthcare Ethics

By

Melissa S. Berdell

May 2016

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Approved April 7, 2016

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## ABSTRACT

# THE SOCIAL OBLIGATION TO REDUCE STIGMA IN ORDER TO INCREASE UTILIZATION OF MENTAL HEALTH SERVICES

By

Melissa S. Berdell

May 2016

Dissertation supervised by Dr. Henk ten Have

Many mental health organizations have developed campaigns that concentrate on reducing the stigma towards mental health with the intentions of increasing access and utilization for people with mental illnesses that are not receiving appropriate mental health services. The mental health campaigns predominantly focus on establishing awareness and education related to the number of people with mental illnesses and diagnoses so that people will not be ashamed or embarrassed to have mental illnesses or access mental health treatments. However, societal prejudices have caused many people diagnosed with mental illnesses to lose jobs, homes, and families; therefore, in general, people are afraid of being diagnosed as mentally ill and seeking mental health treatments. Additionally, recent national attention and media reports of tragic and senseless events caused by people diagnosed with mental illnesses intensified the societal prejudices and stigma towards people with mental illnesses, which have depicted these people as

extremely harmful to themselves and others. Consequently, societal demands magnified the need for public changes to prevent future tragedies, which contributed to President Barack Obama proposing regulations and policy agendas aimed at reducing stigma towards mental health and increasing access and utilization of mental health services. The mental health campaign initiatives and legislative proposals are supportive to the cause by reducing prejudices and barriers for people diagnosed with mental illnesses, and hopefully, preventing future tragic events. However, the research indicated that there is another barrier to mental health services impacting the lower levels of access and utilization.

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## **Chapter 1 – Introduction**

### **Issues Influencing Access to Mental Health Services**

Many mental health organizations have developed campaigns that concentrate on reducing the stigma towards mental health with the intentions of increasing access and utilization for people with mental illnesses that are not receiving appropriate mental health services. The mental health campaigns predominantly focus on establishing awareness and education related to the number of people with mental illnesses and diagnoses so that people will not be ashamed or embarrassed to have mental illnesses or access mental health treatments. However, societal prejudices have caused many people diagnosed with mental illnesses to lose jobs, homes, and families; therefore, in general, people are afraid of being diagnosed as mentally ill and seeking mental health treatments.<sup>1 2</sup> Additionally, recent national attention and media reports of tragic and senseless events caused by people diagnosed with mental illnesses intensified the societal prejudices and stigma towards people with mental illnesses, which have depicted these people as extremely harmful to themselves and others<sup>3</sup>. Consequently, societal demands magnified the need for public changes to prevent future tragedies, which contributed to President Barack Obama proposing regulations and policy agendas aimed at reducing stigma towards mental health and increasing access and utilization of mental health services.<sup>4</sup> The mental health campaign initiatives and legislative proposals are supportive to the cause by reducing prejudices and barriers for people diagnosed with mental illnesses, and hopefully, preventing future tragic events. However, the research indicated that there is another barrier to mental health services impacting the lower levels of access and utilization.<sup>5</sup>

Another barrier for people with mental illnesses is the stigma towards mental health professionals and treatments that is impacting utilization of services because of the people are fearful or have misconceptions of mental health services. Previously, the imperfect history of mental health services including treatments such as convulsive therapies, electro-shock therapies, lobotomies, and antipsychotic pharmaceuticals has elevated public concerns with the medical model regarding consent, safety, and confidentiality. The images of patients with mental illnesses being forced into painful and ineffective treatments at asylums have raised questions about the legitimacy of early psychiatric practices. The images of psychiatrists abusing or testing on people labeled as “mad” or “insane” became the public perception of mental health treatments and was exacerbated by the entertainment and media reproductions of these images.

Diverging from the public concern and portrayals, there are movements and evidence to support that psychiatric and mental health treatments are evolving and supporting positive outcomes for the recovery<sup>6</sup> of people with mental illnesses.<sup>7</sup> To encourage and legitimize the mental health practices and treatments that were producing benefits and demonstrating outcomes, many of the oversight and advisory agencies, including the American Psychiatric Association, have progressed in establishing ethical practice and patient safety standards that protect people with mental illnesses.<sup>8</sup>

Even though mental health services are increasing in general, there is still a reluctance within our society for people to access mental health services. The reluctance to access mental health services has been driven by stigma and societal prejudices against people seeking treatments for mental illnesses. The prejudices and perceptions have entrenched society with stigma that people diagnosed with mental illnesses are dangerous, insane, and dependent.<sup>9</sup> Moreover, the prejudices and perceptions have produced stigma that mental health treatments are unsafe,

coerced, and futile. Consequently, people with mental illnesses are avoiding the labels, such as mad or insane, and dreading the mental health treatments that are portrayed as harmful and involuntary. Therefore, the mental health campaigns must compound the awareness and education to address the stigma and fears towards both mental health illnesses and treatments in order for the culture of the society to understand the need for additional access and utilization to reassure and assist the millions of people in the United States without appropriate mental health services.

In Chapter 2, an overview of mental health services will be utilized to understand the mental health diagnoses and treatments along with pinpointing significant events in mental health services. Based on the overview, Chapter 3 will define stigma and determine how stigmatization has magnified the discrimination towards people with mental illnesses based on stereotypes and caused fears reducing access to mental health services. In Chapter 4, the consequences of the stigma will be counterbalanced with the ethical practice and patient safety standards, approval of legislation for parity and access, and the importance of education and awareness. Subsequently, Chapter 5 will expand on education and awareness aimed at reducing stigma towards mental health and evaluate the effectiveness of the current mental health campaigns while justifying comprehensive programs that include reduction in stigma towards people with mental illnesses and fears of mental health services. Based on social obligations to increase access and utilization, Chapter 6 will review community mental health models, methods to deter harm and tragic events without increasing stigmatization within the general public, and consideration of future legislation. Finally, Chapter 7 will conclude with an overview of the importance of comprehensive and multi-faceted anti-stigma campaigns.

## **Reducing Stigma**

According to the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality, in 2012, 42 million adults in the United States reported some type of mental illness within the 12-month period.<sup>10</sup> However, only 32 million of those adults received mental health services or treatments.<sup>11</sup> Therefore, there is a social obligation to reduce stigma to increase the utilization of the mental health services, since stigma of mental illnesses and treatments result in the largest reduction on the medically necessary mental health services. In recent reviews by SAMHSA, there is evidence to support that anti-stigma awareness is increasing the utilization of services.<sup>12</sup> Subsequently, if mental health campaigns addressed the stigma towards mental health by including both the fears associated with mental health diagnoses and treatments, then access and utilization could increase to help cover the millions of people in the United States that are still not receiving medically necessary mental health services.<sup>13</sup> Furthermore, if the mental health campaigns redirected awareness and education to focus on positives related to recovery of mental illness and safe mental health treatments as outlined in the practice standards, then the negative perceptions from public opinions and media attention may diminish the stigma towards mental illnesses and treatments. This doctoral project will ethically justify the need for comprehensive mental health campaigns that integrate the progress in mental health treatments, ethical practices and patient safety standards that have been implemented so that stigma is reduced, people with mental illnesses are less afraid of the diagnoses and treatments, and access and utilization are increased.

To understand the justification for social obligations related to mental health awareness, a historical overview of mental health symptoms, classifications, treatments, and events will assist

in pinpointing the stigma towards mental health illnesses and treatments that is reducing utilization of mental health services in the United States. Additionally, referencing international references will allow us to further expanded upon the needs for the populations with mental health illnesses and consider awareness and anti-stigma options that could further increase the utilization of mental health services. Throughout history, many societies, including the United States, have been exploring methods and practices to reduce or eliminate the symptoms, behaviors, and problems with people that are categorized as “mad,” “crazy,” “mentally ill,” and “insane.”<sup>14</sup> Historical records indicated that perceived madness or mental illness (more recent categorization) was causing people to have “unusual and scary behaviors” that interfered with basic living functions and reduced the quality of life.<sup>15</sup> Additionally, there were perceived threats to the general society because of the abnormal and unpredictable behaviors and emotions that were causing public disobedience and crime.

### **Overview and Outline of Mental Health Services**

Throughout history, there are references to the madness, craziness, and mental illness and many attempts to contain, reduce, and eliminate the symptoms. The references to madness and efforts to reduce mental illnesses are dated as early as the ancient times in 400 BC.<sup>16</sup> Subsequently, as madness was further investigated, there was still a lack of understanding what caused or cured madness, with both continuing to be a mystery today.<sup>17</sup>

As the investigation into the mystery of madness continued, there was a transition from the term madness to mental illness in the 1900s as the medical models and advanced psychiatric practices were introduced because of the discovery that functions in the brain are related to the mental illnesses.<sup>18</sup> The change in definitions and transitions in treatment are evident throughout

the history and can be delineated into the following major eras of psychiatry defined by Greg Eghigian and Gail Horstein: (1) The Pneumatic Age, (2) The Age of Optimism, (3) The Militant Age, and (4) The Psychoboom.<sup>19</sup> More recently, the investigation of mental health has concentrated on the promotion of wellness, which permits for earlier detection of mental illness and sooner access to services.<sup>20</sup>

Early detection and intervention is important for positive mental health outcomes; however, “mental illness is difficult to diagnosis, because, there are few biological markers.”<sup>21</sup> Currently, mental illness is classified into groups and the treatments are to reduce and maintain the symptoms that are common within the different classifications of mental illnesses and disorders.<sup>22</sup>

The uncertainty of causes and cures has brought questioning to practices of psychiatry; however, as psychiatry advances, the medical model has highlighted evidence that supports mental health treatments are producing outcomes that effectively manage the symptoms of mental illness and allow people with mental illnesses to function in society. Additionally, the beginnings of a post-psychiatry era are leading to more ethical and safe practices that are dependent on humanistic and psychoanalytic approaches while relying on effective practices of psychiatry. Since mental health services are producing positive outcomes and the percentage of people with mental health illnesses and disorders remains high, there is a societal need to increase the utilization of mental health services. However, there are still many barriers that are reducing the utilization of mental health services.

## **Stigma towards People Seeking Mental Health Services**

To understand the barriers to mental health treatments, the demographics of the populations with mental illnesses must be defined. In reviewing the demographics of people with mental illnesses, the main factors potentially impacting mental illnesses and treatments are the following: age, gender, race, and socioeconomic status.<sup>23</sup> When comparing the ages of people with mental illnesses, the percentage rates increase between 20 and 30 years old and then continue to decrease after 30 years.<sup>24</sup> However, there are increases in mental illnesses at the end of life.<sup>25</sup> When reviewing the demographics of race and gender, these demographics have less impact on the percentage of people with mental illnesses; however, each of the race and gender classifications have different responses and accesses to mental health services.<sup>26</sup> Finally, when considering the demographics of mental illnesses, socioeconomic status was most influential on the rate of mental illnesses. Furthermore, there was analysis to determine whether poverty causes mental illnesses or mental illnesses result in poverty.<sup>27</sup> Therefore, considering access to mental health services, there continues to be a need to consider the differences in demographics when considering barriers to medically necessary mental health services. The different mental illnesses and demographics may result in different approaches to treatments and access, but the most common barrier to mental health services across the populations and demographics of mental illness remains to be stigmatization.

The most common and relied on definition of stigma though out the literature is drawn for the theory of Link and Phelan.<sup>28</sup> Link and Phelan defined the following four components to assist with understanding the definition of stigmatization: 1. Distinguishing and labeling differences, 2. Associating the human differences with negative attributes, 3. Separating “us” from “them,” and 4. Status loss and discrimination.<sup>29</sup> The root of stigma towards mental illness

was derived from the way society views people with mental illnesses.<sup>30</sup> The societal views that have stigmatized mental illness stem from the early misconceptions of the people that were labeled as “mad” and “crazy.” Secondly, society tends to emphasize the symptoms that have negative consequences that result in violence and harm. Consequently, society has historically separated people with mental illnesses from the general public and decreased contact with the general public. Therefore, people with mental illnesses tend to suffer loss in access to employment, housing, health care, and social status.

These components of stigma toward mental illnesses were evident as early as the Pneumatic Ages and still exist today. Even though, the actors and reasons for stigmatization may be changing, the primary components of stigma, such as stereotypes, prejudices, and discriminations are still present.<sup>31</sup> In American culture, the stigma towards people with mental illnesses and/or seeking mental health services perpetually worsened as people were separated from the society, remained uncured, and negatively portrayed in the media. Furthermore, the stigmatization is not only directed at the mental health illness diagnoses, but has resulted in a fear directed at mental health services. Society and people with mental illnesses are now fearful of the mental health professionals and psychiatric practices.<sup>32</sup> The fear of the mental illness and psychiatric practices is based on the imperfect history of mental health including treatments such as convulsive therapies, electro-shock therapies, lobotomies, and antipsychotic pharmaceuticals which had created stereotypes of suffering.<sup>33</sup> Based on the analysis of stigma, the stereotypes have elevated societal prejudices and labeled psychiatry as unethical, questioning basic principles of consent, safety, and confidentiality.<sup>34</sup> Overall, the stigma and negative attitudes towards mental health services caused the fears that result in disapproval and separating the people with mental illnesses from medically necessary treatments causing injustices with the

healthcare system.<sup>35</sup> The major consequence to the stigma towards mental illnesses and the necessary treatments was inadequate access and utilization of mental health services.<sup>36</sup>

### **Reeducating and Changing Public Opinion to Reduce Stigma**

“America has always struggled to care and support people have mental illnesses,”<sup>37</sup> Whitaker’s historical analysis of people with mental illnesses specifically schizophrenia multiplies the struggle and concludes that America’s stigmatization and treatment of people with mental illnesses has resulted in a complete failure.<sup>38</sup> Based on the impressions of inadequate and potentially harmful treatments, people with mental illnesses are not only fearful of the stigmatization but are also fearful of the stigma towards clinicians and professionals providing the treatment. To the contrary, the National Institute of Mental Health (NIMH) continue to support that there have been significant advances in mental health treatments and has developed strategic objectives specific to “transforming the understanding and treatment of mental illnesses.”<sup>39</sup>

Similar to the NIMH, there is evidence to support attempts to promote mental health awareness and reduce stigma towards people with mental illnesses increase utilization of mental health services. Moreover, NIMH and similar organizations have attempted to reduce fears in regard to mental health treatments, which include validating the medical model with evidence-based treatments, implementing ethical practice and patient safety standards, and enacting legislation that would ensure parity and access. All initiatives related to mental health services tend to aim at increasing access and utilization to mental health treatment and reducing the stigma towards mental health. However, many of the initiatives are fairly new, and the general public may not be aware of the advancements in mental health and psychiatric treatments.<sup>40</sup>

Therefore, awareness and education specific to the advancements is necessary to counteract previous negative perceptions of mental health treatments.

Many Federal and State programs have taken on the responsibility to address the stigma towards mental health illnesses and treatments to ensure that people with mental illness receive needed treatments.<sup>41</sup> The Federal legislation has been focused on ensuring that Americans have access to mental health treatments; however, many insurers and payors were unwilling to reimburse for mental health treatments because of the stigma and the legitimacy of some mental health treatments. Since the legitimacy of mental health treatments has been questioned throughout history, insurers and payors typically have had reduced availability and reimbursements for mental health services compared to physical health services. Additionally, the insurers and payors created other barriers to access for mental health services, such as lengthy pre-authorization processes, that were not present for comparable physical health services.<sup>42</sup>

In the United States, there were several tragic events caused by people with mental illnesses that had society demanding for better understanding of mental illnesses and access to mental health services.<sup>43</sup> Also, mental health organizations, such American Psychiatric Association and SAMHSA, were lobbying for increased mental health services since the practices were become more beneficial, ethical, and humanistic and were producing outcomes for the people with mental illnesses. In 1996 and with a final rule in 2013, the Mental Health Parity and Addiction Equity Act was passed to require insurance companies and medical coverage payors to reimburse for mental health services in the same manner that physical and surgical services.<sup>44</sup> Additionally, the Mental Health Parity and Addiction Equity Act prohibited restrictions on mental health services from any type of insurance mechanisms, such as copays, medical necessity criteria,

provider networks, and benefit limitations that would make mental health services more difficult to access than physical and surgical services.<sup>45</sup> Furthermore, the enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) was expanded in the Patient Protections and Affordable Care Act (PPACA) to ensure that people with mental health or substance abuse illnesses are able to receive medically necessary services without restrictions or barriers imposed by insurers or payors.<sup>46</sup> The legislation movements advocating for mental health services are beneficial for both increasing availability of mental health services while reeducating the general public on mental health illness and treatments to reduce stigmatization and encourage people with mental illnesses to seek treatments.<sup>47</sup>

Another approach at to address the stigma towards mental health illnesses and treatments is to reeducate on the innovations and advancements that are occurring within psychiatry and mental health treatments, which are the implementation of Ethics Practice and Patient Safety Standards and the expansion of evidence based treatments. One of the most practical methods to reduce the stigma and fears in relation to mental health treatments is to validate the medical model practices of psychiatry that incorporate psychotherapies and other evidence based treatments to ensure that patients are receiving treatments that are beneficial and safe.<sup>48</sup> Between the scholars of evidence based practices in psychiatry and mental health, there is significant progress documented on the technology and advancements in psychiatric treatments that is causing people with mental illnesses to become better through more accurate diagnosing, safer pharmaceutical management, and increased humanistic therapies.<sup>49 50</sup>

Moreover, the sciences of psychiatry and psychology are combining with physical medicine to consider diagnoses and treatments of mental illnesses. The science of diagnosing mental illness is shifting to consider the whole person including internal and external influences that

may be causing the symptoms and behaviors.<sup>51</sup> When the diagnosing process considers all the influences of the person and not just the chemicals in the brain, then mental health treatments are more effective and support ethical and humanistic approaches.<sup>52</sup>

Together, as the science of diagnosing and the psychiatric treatments become more advanced and evidence-based practices are implemented, the fears related to ineffective and unnecessary treatments are decreased while also reducing the stigma towards both mental illnesses and treatments.<sup>53</sup> Eventually, as psychiatry and mental health treatments are validated, this could prompt more people with mental illnesses to seek and receive both psychiatric and psychological treatments that reduce symptoms and promote recovery for people with mental illnesses to live, work, and interact within the general public.<sup>54</sup> This new movement of mental health services, known as post-psychiatry, will reaffirm safe and beneficial practices while encouraging non-traditional psychotherapies that promote recovery for people with mental illnesses.<sup>55</sup>

To increase the validity and utilization of mental health services and decrease the stigmatization for people with mental illnesses, psychiatrists and psychotherapists must establish and embrace professionalism, ethical practices, and patient safety, so that the millions of Americans with mental health services will want to seek medically necessary treatments.<sup>56</sup> This is supported by the concepts of professionalism that are presented in the Codes of Ethics linking the importance of professionalism, ethical practices and patient safety with the levels of vulnerabilities and sensitivities that people with mental illnesses encounter.<sup>57</sup>

Subsequently, the American Psychiatric Association implementation of the Ethical Practice and Patient Safety Standards to combat the scrutiny that psychiatry has infringed on basic medical ethics principles, such as confidentiality, safety, and autonomy. With the implementation of the ethical principles, the American Psychiatry Association anticipates that

the promises of medicine can be restored to patients and additionally to “society, to other health professionals, and to self.”<sup>58</sup>

Combining the advancements in mental health treatment and implementation of the ethical standards, awareness campaigns could be even more effective at reducing the stigma towards mental illness along with stigma towards mental health services and the people receiving the treatments. Corrigan, et al. (2012) have argued that misconceptions and negative attitudes towards mental health can be changed by relaying accurate information to the general public through the following methods: education, contact, and protest.<sup>59</sup> The first and most popular method to increase awareness and provoke change is to provide education to the general public so that facts can replace myths.<sup>60</sup> The second and the most successful method is actual contact with people with mental illnesses or treatments, such as communities interacting with people with mental illnesses.<sup>61</sup> Finally, the third and the least utilized method is protest or social activism, using shame to discourage the public from labeling people as mentally ill.<sup>62</sup> Since education and contact have proven to have positive influence on stigma, these two methods of change are the most frequently used methods. The third method of protest is used less often because this method can result in “rebounds,” because the method of protest is based on shaming the prejudices instead of changing the prejudices.<sup>63</sup>

Since education and contact have positive outcomes, these are the most logical approaches to the promotion of awareness about people with mental illnesses and reduction of the fears towards mental health treatments.<sup>64</sup>

## **Validation of Mental Health Awareness Campaigns**

In 2012, according to the SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center), there are different types of mental health campaigns that have incorporated education and contact. This website outlined mental health campaigns with the missions of "educating the public to help eliminate the misperceptions and biases that keeps people with mental illnesses from living, working, and participating in the community."<sup>65</sup>

Moreover, the SAMHSA website reported that discrimination and stigma towards people with mental illnesses is primarily based on inaccurate information; therefore, most of the mental health campaigns focus on reeducating the general public to reduce and replace the stigma toward people with mental illnesses. This type of education, known as anti-stigma campaigns, appeared to be the most popular with several hundred campaigns found locally and throughout the world.

Also, on the SAMHSA's website, there were details of more recent effort, known as the Social Inclusion Campaign, which relies on education with more focus on contact with people that have mental illnesses. The Social Inclusion Campaign goes further than awareness about mental illnesses by considering ways to promote communities to accept people with mental illnesses in daily interactions. The Social Inclusion Program encourages communities to allow for people with mental illness to be given the same "social, economic, educational, recreational, and cultural opportunities that most citizens take for granted"<sup>66</sup>

Along with addressing the stigma towards people with mental illness, there were a few mental health campaigns that concentrated on the negative attitudes towards mental health treatments. This type of education was less popular; however, the negative attitudes and fears of

treatment are still a significant barrier decreasing access and utilization to mental health treatments. Furthermore, most of the campaigns that focus on stigma and fears of mental health treatments are based on education methods and did not include contact with mental health treatments or psychiatric treatments.

### **Social Obligations**

Since mental health campaigns are providing positive outcomes, there is a social obligation to increase awareness that reduce stigma, promote wellness, and address current considerations for people with mental illnesses.

The most current consideration would be based on the movement to community mental health models that integrate people with mental illnesses into the communities. Secondly, for the community mental health models to be successful, there must be methods to introduce the communities to crisis and safety plans to divert harm and tragic events without increasing stigma towards people with mental illnesses.<sup>67</sup> These efforts can be achieved by including comprehensive awareness campaigns that reduce stigma and promoting effect and ethical mental health treatments.<sup>68</sup>

In consideration of post-psychiatry, there are movements in process to transition people with mental illnesses from state mental hospitals to community settings with outpatient mental health services.<sup>69</sup> Many people with mental illnesses function and live within communities without many disruptions; however, these newer movements could put people with severe mental illnesses that have been dependent on inpatient services for years into communities without the same level of assistance. Complications can occur when people with severe mental illnesses are taken out of mental hospitals and placed back into the general public.<sup>70</sup> This project will analyze

the ethical concerns relating to the effect that releasing people from mental hospitals to the general public could increase stigmatization; however, with comprehensive campaigns stigma can be reduced for people with mental illnesses and awareness of effective and ethical practices will promote utilization of mental health services.<sup>71</sup>

As post psychiatry advances and more people with mental illnesses are living within the communities, there are potentials for harm and tragic events and other community concerns.<sup>72</sup> These potentials should be counterbalanced with the increased access and utilization of mental health services available to the people with mental illnesses within the communities.<sup>73</sup> However, there is still the potential for harm and tragic events. Again, the mental health campaigns should consider initiatives that would support and encourage safety and crisis plans within the communities that could deter harm and tragic events. And more importantly, the mental health campaigns should determine ways to introduce these practices without increasing stigmatization.

Recently, President Barack Obama's commitment to the Mental Health Parity Act demonstrated mental health awareness that can address issues of safety while also preventing further stigmatization of people with mental illnesses.<sup>74</sup> Additionally, President Obama started anti-stigma efforts through other public policies based on tragic events that have been implemented in the OK2Talk and WH.GOV programs.<sup>75</sup> Similar consideration will be examined to help addressing the possibility that symptoms and behaviors of mental illnesses can result in harm; however, many times crisis and safety plans can be created to diffuse situations to prevent harm and tragic events.<sup>76</sup> Ultimately, mental health campaigns that address effective and ethical psychiatric practices can assist families, friends, neighbors, and communities with the appropriate information to ensure that the people with mental illness access medically necessary treatments.

## Chapter 2 – Overview and Outline of Mental Health Services

The current evidence-based and patient-entered treatments of mental health services combining psychiatric and psychological practices is the aftermath of a long disconcerting history of practices towards people labeled as mad, insane, and mentally ill. Even today, the horrific accounts and images of the hysterically insane and mad being coerced into clinical experimentation and aggressive therapies has affected the perception of mental health treatments. In *Mad in America*, this progression of treatment was lucidly described as follows:

Whether it be whipping the mentally ill, bleeding them, making them vomit, feeding the sheep thyroids, putting them in continuous baths, stunning them with shock therapies, or severing their frontal lobes – all such therapies worked at one time, and then a new therapy came along, they were suddenly seen in a new light, and their shortcomings revealed.<sup>77</sup>

The reflection and progress from previous eras has increased the accuracy of diagnosing and effectiveness of treating different mental illnesses in this contemporary era of mental health treatments. Even though mental health treatments have been successful at producing positive outcomes for people with mental illnesses, the professionalism of psychiatry and psychology are continually compared and scrutinized, primarily, because the actual pathology of most mental illnesses has still not been discovered and the research is limited.<sup>78</sup> However, the current expansions in the medical model and evidence-based mental health treatments coupled with multi-dimensional approaches and the promotion of mental health has cultivated mental health services with positive outcomes allowing people with mental illnesses to move closer toward recovery.<sup>79</sup>

The purpose of this chapter is to explain the history of the mental health and to outline the origins of stigma towards people with mental illnesses and the reluctance for people to access mental health services. Additionally, this chapter assists in demonstrating the progression of mental health services with modern medical models and pharmaceuticals but also the advancements in the humanistic and psychoanalytic approaches. Overall, this chapter will examine the historical abuses while transitioning mental health treatments to evidenced-based and value-based practices that are helping people overcome psychiatric symptoms and psychological distress.

### **History of Mental Health Services**

Madness and mental illness have been documented in almost all societies and present throughout history.<sup>80</sup> The definitions and use of madness and mental illness were mainly dependent on the era, society, and treatment of people with mental illnesses. To understand the original perceptions of madness and treatments, each of the eras were considered with the following three domains: the intellect of the previous era, the societal and institutional perceptions of people with madness or mental illness, and the science including terminology and treatments.<sup>81</sup> Contextually, *In Madness to Mental Health*, Egighan and Horstein used the three domains of the history to categorize and define eras based on documented accounts of madness and mental health: 1. The Pneumatic Age, 2. The Age of Optimism, 3. The Militant Age, and 4. The Psychoboom.<sup>82</sup>

From Ancient times into the 18<sup>th</sup> century, the Pneumatic Age resulted in explanations of madness that were conditional on physical and metaphysical maladies.<sup>83</sup> For the first domain of intellectual history, the writings of Hippocrates reported madness as an “imbalance” within the

body of the fundamental fluids of blood, phlegm, and bile.<sup>84</sup> This whole body and spirit approach was documented in the Bible which stated “human rationality, passions and desires” had “somatic and spiritual dimensions” which caused the madness.<sup>85</sup>

Consequently, the lack of history and understanding specific to madness led to societal misconceptions, isolation, and mistreatment of the mad.<sup>86</sup> Within the documentation from the Pneumatic Age, madness was depicted by people having episodes of the mania and insanity that was troublesome and inconvenient to other people in society.<sup>87</sup> During the Medieval times, there was documentation that people deemed mad or insane were “incompetent” to enter into legal agreements or contracts and were not held responsible for crimes.<sup>88</sup> Also, during the Pneumatic Age, the societal perceptions ensued significant restrictions and isolation for people deemed mad. The societal ignorance of the mad introduced the traditional asylums. In the asylums, the mad were treated like prisoners and “regularly flogged, bounded in chains, and subjected to stupefying hygienic conditions.”<sup>89</sup>

The science and experimental history of madness was elementary, however, the literature of the Pneumatic Age noticed differences in types and severities of madness. In the texts of this era, the first form of madness referenced was phrenitis or frenzy.<sup>90</sup> Phrenitis was an acute disease typically inflammation that resulted in periods of acute confusion and delirium.<sup>91</sup> Another form of madness recorded in the Pneumatic Age was melancholy. Melancholy was used to describe people with chronic episodes of fear, anxiety, and sadness. Finally, the third form described in the Pneumatic Age was mania.<sup>92</sup> Mania was recorded as chronic disturbances with significant episodes of delusions and anxiety.<sup>93</sup> Subsequently, the different classifications of madness did not necessarily change the treatments or isolation. However, people with severe madness, insanity, and/or hysteria<sup>94</sup> were isolated or locked away from society, treated and

referred to as animals or savages, and endured depilating treatments and priest-like doctors induced extreme body debilitating therapies, such as vomiting, water submergence, and bloodletting. The aggressive treatments of the mad were to purge of the body of toxins that were perceived to be throughout blood, phlegm, and bile of the body and cleanse the evil from the spirit.

The next era was the Age of Optimism which began in the 18<sup>th</sup> century and continued through the 19<sup>th</sup> century included the Enlightenment, Romanticism, and Reform periods. In the Enlightenment, the reflections of torture and isolation from the previous era united with progressive movements of equality led to optimism for the mad.<sup>95</sup> With emergent optimism, researchers, scientists, physicians, and policymakers delineated that people with madness could be cured with treatments allowing the mad to be part of society.<sup>96</sup> Furthermore, the advancements in intellect and aspirations to discover treatments and cures increased the scientific experimentation of the mad.<sup>97</sup> The experimentation and eagerness to explore the science of madness led to the concept of “mad-doctors.”<sup>98</sup> In the 19<sup>th</sup> century, the United States and Europe reconstructed asylums with therapeutic setting supported by the doctor-patient relationships.<sup>99</sup>

During the Age of Optimism, the societies were still ambiguous on madness and accepting that some people with severe madness were incurable, but realizing that some people with madness could be “understood and cured.”<sup>100</sup> Society demanded moral treatment and supported that people with madness be cured and returned into their communities. However, in reviewing the historical accounts of societal and institutional factors, the severely mad remained isolated in the therapeutic asylums.<sup>101</sup> The structure of the new therapeutic asylums filled with “raving lunatics” presented opportunities for the mad-doctors to experiment and potentially

discover treatments and cures for madness.<sup>102</sup> As a result, the therapeutic asylums transformed into research laboratories and patients were coerced to be research subjects.<sup>103</sup> The transformation of asylums further distorted society's view with shocking images of mad-doctors experimenting on human subjects.<sup>104</sup>

The Age of Optimism was responsible for evolving the science and terminology of madness to illness of the central nervous system and brain. Additionally, the Age of Optimism embarked on the study of the "psyche."<sup>105</sup> Based on the evolution of the science during the Age of Optimism, the science of neurology and psychology became prevalent, and the professions experienced rapid increase. The science of psychology was based on the psyche and founded on the ideology that madness and mental illness was a "disturbance of the soul;" consequently, this would require physicians to change treatment methodologies that were only addressing physical maladies.<sup>106</sup> The physicians of psychology considered the impairments to the soul that were impacting the "mental life" of people with mental illnesses. However, even in the early developments of psychology, the physicians discovered that the appearances and symptoms of mental illnesses were quite different for every individual. During this period, the physicians of psychology treated conditions of the psyche, such as, mental breakdowns, aberrations of reason, madness, disease of temperament, and mental disease.<sup>107</sup> Along with psychology, the 19th century introduced the science of neurology. Neurology expanded the science of madness from not only a disturbance of the psyche, but maladies of the brain and nervous system. From the expansion of the asylums and experimentation of the mad, the mad-doctors began to explore nervous and brain pathology. From studying the symptoms and experimentation of people the neurologist were documenting conditions, such as, shattered nerves, nervous collapse, nervous

exhaustion, and nervous breakdown were given to people that were experiencing symptoms of madness.<sup>108</sup>

Following the Age of Optimism, society was considerably depleted of human and capital resources because of the wars between the nations over varying ideologies in equality and human rights. Since war was the focal point, this era was categorized as the Militant Age. The wars were using all the resources, therefore, the progression of the sciences of madness and mental illnesses experienced substantial obstacles and began to regress.<sup>109</sup> However, the country leaders and war officials rekindled interest with mental illnesses for the following two reasons: 1. Soldiers were becoming crazed and reducing human resources on the battlefield and 2. Asylums were growing large and expensive which reduced capital resources needed for war.<sup>110</sup> The first reason mental health was reconsidered during this time was the soldiers began to exhibit insane or mad symptoms were sent to hospitals; because the asylums were unsuccessful at recoveries, and the officers needed the soldier to return to war. With the war resources funding the hospitals, the physicians were able categorize the soldier insanity as a breakdown of the nervous system because of the trauma experienced from war. The physicians labeled this condition “traumatic neurosis.”<sup>111</sup> Secondly, mental illnesses were reexamined when the asylums began to overcrowd with people who were severely psychotic or insane with no prognoses of recovery. The asylums were draining public funding and resources that could have been allotted for war.

The societies during the Militant Age began to be pessimistic about psychiatry and began to consider people with mental illnesses as “morally-feeble” minded or incurably insane.<sup>112</sup> Additionally, in early 20<sup>th</sup> century, the asylums began to segregate the curable populations from the incurable populations.<sup>113</sup> With all of the people with incurable mental illnesses in one asylum, the prognoses became grimmer. During the 20<sup>th</sup> century, the United States was

presented with the science of eugenics.<sup>114</sup> The eugenics movement reinforced a superior race with specific characteristics and abilities; subsequently, people considered inferior, such as people with mental illnesses, experienced discrimination and loss of human rights.<sup>115</sup> As the eugenics movement thrived among the affluent in the United States, the people with incurable mental illnesses were labeled as “social wastage,” “malignant biological growths,” and “poisonous slime.”<sup>116</sup> Consequently, society and medicine began to demand sterilization for people with severe mental illnesses; and eventually entertained euthanasia for people with incurable insanity. Whitaker cited the following quote, “The insane of at least those who committed any sort of crime, should be humanely and economically disposed of in small euthanasia institutions supplied with proper gases.”<sup>117</sup>

In general, during the Militant Age, the science and medicine did experience some outcomes from treatments, such as, sedatives, hydrotherapies, and electrotherapies.<sup>118</sup> Moreover, the Militant Age continued to rely on treatments that attacked the whole body with fevers and/or seizures and deliberately destroyed functions of the brain<sup>119</sup> that were perceived to cause the madness.<sup>120</sup> The treatments introduced during this era included the lobotomy, malaria fever therapy, insulin therapy, and metrazol therapy.<sup>121</sup> Additionally, with unreliable outcomes from diagnosing and treating, the societies were beginning to accept that some people were “mentally dead.”<sup>122</sup> Eventually, the idea of the mentally dead coupled with eugenics movements resulted in the aggressive mental health treatments to transition to the unfathomable killings of people with mental illnesses. Egighan and Horstein reported that the eugenics movements accounted for the 300,000 deaths of people categorized as “morally feeble minded” and over 200,000 deaths of incurable psychiatric patients.<sup>123</sup> Finally, the Militant Age concluded with the anti-psychiatry

movement rejecting the aggressive treatments, sterilizations, and killings of people with mental illnesses in the name of psychiatry.<sup>124</sup>

As a result of the anti-psychiatry and psychiatric reform movement, the Militant Age ended with society demanding for the psychiatry to be rehabilitated and to address “human rights” for people with mental illnesses.<sup>125</sup> The reform of psychiatry called for changes in diagnosing and treating which transitioned to the Psychoboom Era that propelled mental health services into the mainstream of society. The intellect relied predominantly on the efficacy and evidence of the treatments for mental health disorders. Subsequently, the clinical trials and observations of mental health disorders promoted accurate diagnosing and beneficial treatments and began to require ethical standards of research, such as informed consent.<sup>126</sup>

During the Psychoboom Era the stigmatization of people with mental illnesses was decreasing as the people were deinstitutionalized, the mental health professions were expanding because the science had positive efficacy and evidence, and the middle class and mainstream societies were accessing mental health services. Moreover, there was a trend in media such as radio and newspapers to broadcast and publish counseling advice from psychologists and psychiatrists.<sup>127</sup> The Psychoboom Era was responsible for moving the terminology of treatment of mental illnesses to mental health care services.<sup>128</sup> The reformation of the contemporary mental health services resulted in the terminology of mental health patients changing to mental health clients. These deviations in the terminology were significant, because psychotherapies were becoming client-focused services and were much less dreadful than the lobotomies and insulin therapies that were conducted in the previous Militant Era. Even though, there was a transition to cognitive and behavioral therapies and psychotherapies, society was more accepting of the new psychiatric medications because of high positive outcomes for the people with severe

mental illnesses. The transition to contemporary mental health care services allowed for society to accept the different intensities and modalities of mental health treatments available for the differences in mental health diagnoses and severities. This tiered approach appeased society and the demand encouraged the development of client-driven and recovery-focused mental health services.

With the reform of mental health services, the Psychoboom Era was dependent on the scientific experiments demonstrating outcomes for people with mental illnesses; however, there were safeguards implemented to protect the participants of the clinical trials. The outcomes of accurately diagnosing and effectively treating people progressed and allowed for the American Psychiatric Association in 1974 to publish diagnoses and treatments specific to mental disorders by categories, which has been delineated as one of the largest revisions to incorporate the biological and psychological concepts of modern psychiatry.<sup>129</sup> Based on the outcomes of the clinical trials, the science of the Psychoboom Era introduced the following modern psychiatric pharmaceuticals: amphetamines, barbiturates, benzodiazepines, lithium, MAO inhibitors, and tricyclic antidepressants.<sup>130</sup> Additionally, the advancements in accurately diagnosing allowed for expanded efficacy in other mental health services, such as surgery, radiation, psychotherapy, and ECT.<sup>131</sup>

The reform of psychiatry during the Psychoboom Era also resulted in case formations and treatment plans that considered and combined biological treatments along with psychoanalytical and cognitive therapies. However, the science of mental illness is still searching to discover actual pathologies and causes of mental illness. Furthermore, the newest innovations in mental health services are introducing preventive care that promotes mental health wellness even for people that have not been or never will be diagnosed with mental illnesses.<sup>132</sup>

## **Importance of the Medical Model: Diagnosing and Treating**

Throughout the history of madness, the documented accounts of the intellect, society, and science specific to madness consistently promulgated that madness is indeed an illness that can be treated under the medical model.<sup>133</sup> Through the documentation and progression of mental illnesses, there remains a dilemma with scientists and physicians to determine whether symptoms and behaviors are from biological pathologies of the brain or environmental and psychological factors impacting the mental states of the people.<sup>134</sup> In the 20<sup>th</sup> and 21<sup>st</sup> centuries, the existing theories of madness have concluded that mental health illnesses can be attributed to “medically/bodily” diseases or disorders and the environmental or psychological factors of the people can cause some disorders and exacerbate the symptoms and behaviors of the underlying mental health illnesses.<sup>135</sup> Under scientific validation and scrutiny of psychiatrists, educational systems, and pharmaceutical companies and by recognition of the National Institute of Mental Health (NIMH), mental health lobby groups, and most mental health providers, the modern psychiatric medical model has been upheld as the decisive methodology for diagnosing and treating people with mental illnesses or disorders.<sup>136</sup>

Although the history relied, studied, tested, categorized, and treated madness as a brain illness, the science has been unable to delineate the definite cause or the biological, psychological, and environmental markers of the mental health illnesses.<sup>137</sup> Contrary to the determinants of mental illnesses, the modern psychiatric medical model of treating diagnoses by specific categories reported positive outcomes and efficacy, therefore, these methodologies of the modern psychiatric medical model became popular and the accepted practice by most mental health professionals and organizations.<sup>138</sup> The positive outcomes from the modern psychiatry medical model and contemporary practices resulted in an upsurge of psychiatric and

psychological services, expansion of mental health professions to counselors, case managers, social workers, and psychiatric nurses, and increased beneficial outcomes from accurate diagnoses and effective treatments.

In the 1970s, psychiatry and psychology thrived with expanded mental health services and increased precision in diagnosing and treating; accordingly, the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) by the American Psychiatric Association was published to document and support the developments of the modern psychiatric medical model.<sup>139</sup> The DSM III was accepted and distinguished as the first “uniform standards” for diagnosing and treating that was particularly designed to assist with mental health research, publications, funding, and insurance coordination.”<sup>140</sup> Currently, the Diagnostic and Statistical Manual of Mental Disorders is still recognized as the paramount guide to diagnosing and treating mental health disorders and continues to be reevaluated and adjusted with positive outcomes.<sup>141</sup> In 2013, the American Psychiatric Association released the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders and proclaimed the following about the newest revision:

[The DSM-5] is the most comprehensive, current, and critical resource for clinical practice available to today's mental health clinicians and researchers of all orientations. The DSM-5 is used by health professionals, social workers, and forensic and legal specialists to diagnose and classify mental disorders, and is the product of more than 10 years of effort by hundreds of international experts in all aspects of mental health. The criteria are concise and explicit, intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings-inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care.<sup>142</sup>

Originally, most of the mental health organizations, providers, and academic institutions supported the revision of the DSM-5 as terminology and diagnostic criteria was in need of substantial updates. However, the NIMH became contentious about the excessive dependence on biological psychiatry while reducing the considerations of environmental and psychological factors which are also clinically proven to contribute to effective mental health services.<sup>143</sup> The NIMH rebutted the American Psychiatric Association's over-reliance on biological psychiatry with the following precautions when utilizing the DSM-5 as a diagnosing and treating guide:

- 1.) A diagnostic approach based on the biology as well as the symptoms must not be constrained by the current DSM categories;
- 2.) Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior;
- 3.) Each level of analysis needs to be understood across a dimension of function;
- 4.) Mapping the cognitive, circuit, and genetic aspects of mental disorders will yield new and better targets for treatment.<sup>144</sup>

The NIMH argued that the last 40 years of research and practice have determined that mental illnesses are based on all the three factors: biological, environmental, and psychological; and eliminating the environmental and psychological factors would discredit the research outcomes that relied on all the factors being integrated into diagnosing and treating.<sup>145</sup>

Subsequently, the American Psychiatric Association specifically indicated that the DSM-5 “is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment disorder.”<sup>146</sup> Moreover, the DSM-5 does include specific guidance around cultural and other influential factors, such as, cognitive functions,

personality traits, housing, economic status, and relationships that may impact the symptomatology of the mental health disorders.<sup>147</sup>

The DSM-5 has categorized 22 different types of diagnoses, so that clinicians may accurately diagnosis patients and determine prognosis, treatment plans, and potential treatment outcomes through individualized case formulations.<sup>148</sup> Additionally, the DSM-5 established assessment codes to determine if the diagnoses are slight, mild, moderate, or severe through cross-cutting symptom measurement.<sup>149</sup> In considering the historical definition, madness was most often applied to people that would have been labeled as severe mental illnesses, symptoms, and impairments while other people with slight and mild disorders or impairments may have been peculiar or odd. The definition of madness has significantly advanced and expanded to the 22 mental health disorders defined in the DSM-5 into the following categories: neurodevelopment disorders, schizophrenia spectrum and other psychotic disorders, bi-polar and related disorders, depressive disorders, anxiety disorders, obsessive compulsive disorders, trauma and stressor related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, elimination disorders, sleep wake disorders, sexual dysfunction, gender dysphoria, disruptive, impulsive control, and conduct disorders, substance-related and addictive disorders, neurocognitive disorders, personality disorders, paraphilic disorders, other mental disorders, medication induced movement disorder and adverse effects of medication, and other conditions.<sup>150</sup>

For the purposes of this project, the DSM-V classifications are important for outlining the common diagnoses that cause the most significant disabilities, symptoms, and distresses on people are the diagnoses that are classified as serious mental illnesses. Typically, the serious mental illnesses are diagnoses such as schizophrenia, bi-polar disorders, and major and manic

depressive disorders.<sup>151</sup> Even though the symptoms and disabilities for people are different, the labels and stereotypes of people with mental illnesses are typically associated with the symptoms defined in the DSM-V for these mental illnesses that include: schizophrenic episodes of “delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior,” bi-polar episodes of “mania, hypomania, and/or major depression,” and major depression episodes of sad, empty, or irritable moods.”<sup>152</sup> Since these symptoms and diagnoses are most significant on people with mental illnesses, the DSM-5 is valuable for distinguishing mental illnesses, the severity of symptoms, and prognoses of treatments.<sup>153</sup> These classifications are important with for advancing mental health treatments and redirecting misconceptions of stereotypes towards people with mental illnesses.

In summary, the DSM-5 was compiled to provide clinicians with a categorically accurate and evidence-based guide for diagnosing and treating people with mental health illnesses and disorders. Even though a diagnosis does not directly equate to specific treatments, the more accurate the diagnoses, the more precise the case formulation will be to develop a positive prognosis, effective treatment plan, and potential outcomes of recovery.<sup>154</sup> Subsequently, the DSM-5 has vested significant dependence on the modern psychiatry medical model of biology and pathology to categorize diagnoses derived from similar symptoms, diagnostic markers, and functional impairments. However, the DSM-5 analytically affirmed that the cultural considerations, societal influences, and familial norms and values have significant influence on the definitions of the mental health disorders, therefore must be considered in the clinical case formulation.<sup>155</sup> Ultimately, the goal of the clinical case formulation is to analyze the diagnostic, clinical, and individualized information to develop a comprehensive treatment plan that

incorporates evidence-based treatments to manage the symptoms of the mental health disorders and support personal recovery.<sup>156</sup>

### **Mental Health Evidence-Based Treatments**

Since the deviations in psychiatric and psychological practices can vary by individual patient and the cause and cure have not been determined, mental health professionalism and services continue to be scrutinized; however, evidence-based practices and treatments have produced empirical evidence to support mental health services can effectively manage the symptoms of mental illness and allow people with mental illness to function in society. The Institute of Medicine, American Psychological Association, and American Psychiatric Association accepted the definition of evidence-based practice to be “the integration of best research evidence with clinical expertise and patient values.”<sup>157</sup> Since evidence-based practice is so prevalent in the practice of medicine and healthcare, the majority of professional health care organizations have accepted (including the American Psychological Association and American Psychiatric Association) the following definition of the evidenced-based practice provided by the Institute of Medicine:

*Best research evidences* refers clinically relevant research, often from the basic health and medical sciences, but especially from patient-centered clinical research into the accuracy and precision of markers; and the efficacy and safety of therapeutic, rehabilitative, and preventive regimes. *Clinical expertise* means the ability to use clinical skills and past evidence to rapidly identify each patient’s unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations. *Patient values* refers to the

unique preferences, concerns, and expectations that each patient brings in the clinical encounter and that must be integrated into clinical decision if they are to serve the patient.<sup>158</sup>

Throughout the 1970s and 1980s, psychiatrists and psychologists of mental health in the medical model have debated whether the biological treatments, such as medications, or psychological treatments, such as cognitive behavioral therapy, were more effective or evidence-based.<sup>159</sup> Despite the fact that mental health services are typically provided in medication and psychotherapy combinations, there is still a tendency for the professions to compare the outcomes of the biological treatments against psychotherapies. The dispute between biological treatments and psychotherapies is rooted with psychiatric treatments having higher reports of evidence and efficacy based on numerous large-scale clinical trials with high outcomes that have been conducted over the years.<sup>160</sup> Whereas the psychoanalytic and psychodynamic therapies have limited clinical based trials, therefore, having less empirical evidence.<sup>161</sup> Likewise, the psychiatric procedures and pharmaceuticals are more likely to be subject to the clinical trials and testing by the United States Food and Drug Administration to ensure safety and effectiveness of the medical interventions.<sup>162</sup> Based on extensive research, the American Psychiatric Association adopted practice standards to include the evidence-based practices for diagnosis and treating to promote positive outcomes and patient safety.<sup>163</sup>

In 1995, the American Psychological Association initiated numerous clinical trials of cognitive, behavioral, and psychoanalytical therapies to prove the therapies are as beneficial to mental health services as the biological interventions.<sup>164</sup> The American Psychological Association was alarmed by the sudden insurgence of pharmaceuticals being introduced and prescribed as mental health interventions.<sup>165</sup> In the 1990s, the rise of pharmaceuticals such as Prozac became mainstream suggesting that pharmaceuticals were the preferred treatment

methods for mental health disorders.<sup>166</sup> Based on the pharmaceutical trends, the American Psychological Association was eager to demonstrate that psychological interventions with clinical data evidence were effective as the pharmaceuticals at treating mental health disorders.<sup>167</sup> The extensive testing of psychological interventions resulted in the American Psychosocial Association posting various psychological practices and treatments and concluded the purpose of evidence-based practices in psychology “is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.”<sup>168</sup>

Along with the professional agencies, the NIMH is a Federal agency under United States Department of Health and Human Services that researches and published evidence-based practices for the diagnosing and treating of mental health disorders.<sup>169</sup> “The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.”<sup>170</sup> The NIMH has been successful at assisting the integration of psychiatric and psychological services to ensure people with mental disorders are receiving evidence-based and safe mental health treatments. Recently, the NIMH guided SAMHSA with evidence-based criteria for the First Episode of Psychosis (FEP) initiative.<sup>171</sup> Understanding that early psychiatric and psychological intervention is important to recovery, the NIMH assisted with FEP treatment program for the people with serious mental illnesses, such as, schizophrenia, bipolar disorder, and major depression.<sup>172</sup> For the FEP treatment program, the following mental health services were recommended team-delivered services that included cases management, employment and educational supports, psychotherapy, family education and support, and pharmacotherapy with primary care physician coordination.<sup>173</sup>

## **Conclusion**

In conclusion, the contemporary mental health services are evidence-based with multi-dimensional approaches beyond the modern medical model and pharmaceutical but encompassing the humanistic and psychoanalytic approaches.<sup>174</sup> The mental health treatments are producing outcomes that are effectively managing the symptoms of mental illness and allow people with mental illness to function in society.<sup>175</sup> However, there are still many barriers that are reducing the utilization of mental health services. According to the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality, in 2012, there were about 10 million adults in the United States that were experiencing some mental health symptoms, but did not access mental health services.<sup>176</sup> With the advancement of mental health services and positive outcomes, there is a social obligation to determine the barriers.

### Chapter 3 – Stigma Towards People Seeking Mental Health Services

In the reflection of the history of mental health services, one of the most significant factors influencing people seeking mental health services is stigma. The stigma of mental illnesses has caused the dehumanization of the people with mental illnesses and allowed society to respond violently and to deny opportunities.<sup>177</sup> The most common and relied on definition of stigma though out the literature is drawn from the theory of Link and Phelan defined as the following four components: “1. Distinguishing and labeling differences, 2. Associating the human differences with negative attributes, 3. Separating “us” from “them,” and 4. Status loss and discrimination.”<sup>178</sup> Stigma was formed from the following fundamental principles:

*Stereotypes:* The beliefs about social groups that characterize “a group as a whole while dismissing person difference or the unique characteristics of persons within the group.”<sup>179</sup>

*Prejudices:* The “unreasoning, unjustifiable overgeneralized and negatively tinged attitudes toward others related to their group membership.”<sup>180</sup>

*Discrimination:* The “unfair treatment of others or harmful actions toward them, based on their membership in separate groups.”<sup>181</sup>

Historically, stigma towards mental illness has resulted in emotional reactions of society that ensued “fear, pity, or scorn” about people with mental illnesses and instigated societal reactions of “banishment, punishment, and neglect.”<sup>182</sup> As a result, mental health services are feared because discrimination has allowed for unethical practices related to safety, consent, and confidentiality.<sup>183</sup>

The purpose of Chapter 3 is to review the evidence and demographics of stigma towards people with mental illnesses and consider the reasons that there are still people not accessing and

utilizing mental health services.<sup>184</sup> The mark of stigma causes both public stigma and self-stigma that results in additional disparities and disabilities to people with mental illnesses that cause people with symptoms and distresses to avoid the label as mentally ill. Ultimately, the stigma results in people with mental illnesses not utilizing mental health services.<sup>185</sup>

### **Evidence and Demographics of Stigma**

There has been evidence of stigma throughout history which “marked” many people with stereotypes resulting in discrimination.<sup>186</sup> Hinshaw reported, “All eras contain traces of past views and precursors of subsequent eras.”<sup>187</sup> As early as Pneumatic Era, ancient texts such as the Bible have recorded accounts of the society discriminating against people with mental illnesses and causing loss of opportunities and rights including death.<sup>188</sup> Presently, the general public is still resistant to accept that mental illness are health maladies like cancer or heart disease; therefore, stigma continues to be evident in our language, laws, and medical and mental health services.<sup>189</sup>

In our language, derogatory terms that imitate mental illness symptoms or historical references have crept into everyday conversations.<sup>190</sup> Some of the statements in everyday conversation that reflect the stigma embedded in our language are the following: “Are you out of you mind?”; “You’re insane!”; “They are crazy!”; “She’s psycho!”<sup>191</sup> These terms that reflect madness and mental disorders are used in the everyday conversation to describe people that have deviated from the normal behaviors of society even though the person is not mentally ill.<sup>192</sup> The misuse of the mental disorders and symptoms prolongs the stigmatization in society.

Additionally, the public media has “perhaps the strongest evidence in modern culture related to stereotyping and stigmatization of mental disturbance” and portrayals of mental

disorders.<sup>193</sup> In most of the public media, the portrayals of mental illnesses have exacerbated the extreme behaviors and severe symptoms of mental disorders.<sup>194</sup> Generally, the media has stereotyped people with mental illnesses as mad and violent.<sup>195</sup> The general stereotypes are evident daily as the media portrays people with mental illnesses as “crazed, killers, incompetent, children, or wild rebellious spirits.”<sup>196</sup> Overall, the stereotypes broadcasted in the media have become society’s illustrations of people with mental illnesses and promulgated dehumanization and discrimination to masses of people based on distorted mimicry.<sup>197</sup>

Finally, the people with mental illnesses or those seeking mental health treatments have reported personal accounts that provide evidence that stigma is experienced.<sup>198</sup> Furthermore, the general public has a tendency to define mental illnesses and view the behaviors and symptoms differently for specific groups of people with mental illnesses.<sup>199</sup> The personal accounts of people and perceptions of the general public revealed that the demographics of the people can affirm the realization and evidence of the stigma. The impact of stigma and the different demographics has been apparent when people are grouped by the following: age, gender, race, and socioeconomic status.<sup>200</sup>

The patterns of age have remained consistent for over 50 years of research and demarked that the age of people can impact the occurrences for specific disorders.<sup>201</sup> When reviewing the people with mental illnesses, the rates of mental illnesses increased when people were between 20 to 30 years old.<sup>202</sup> Subsequently, the occurrence of mental illnesses diminished after the age of 30 while increasing later in life.<sup>203</sup> The psychiatric disorders that occur most frequently in the 20-30 years old range of are depression and bi-polar. Whereas later in life, psychiatric disorders of delirium and dementia tended to significantly increased with the age, and the research specifically reported that between 12-40% of geriatric patients in facility care have delirium.<sup>204</sup>

In addition, age impacted the stigma and perceptions of the general public for people with mental illnesses.

The gender of the people with mental illnesses remained constant when all mental illness was reviewed as an aggregate.<sup>205</sup> However, gender did influence the occurrences of specific mental illnesses. For example, the men had the highest rates of substance abuse disorders; and the women had higher tendencies to experience depression and affective disorders.<sup>206</sup> Furthermore, gender did societal views about people with mental illnesses and impacted the stigma and perceptions of the general public for people with mental illnesses.

The race of people with mental illnesses did not typically increase the likelihood of occurrence as the trends did not indicate significant variances over time.<sup>207</sup> However, in the United States from 1950-1960s, the discrimination of races caused for fluctuation in the frequency rates because of the suffering that the racial discrimination inflicted on non-white populations.<sup>208</sup> Collectively, racial discrimination combined with societal perceptions of mental illness has impacted the frequency and the realization of stigma for people with mental illnesses even though the actual races tend to have insignificant variances on occurrence.

The socioeconomic status of people had been the most influential indicator of mental illnesses when reviewing the occurrence over the years.<sup>209</sup> In reviewing the socioeconomic status, the income, education, and occupation were considered; and the lowest socioeconomic states had the highest frequencies of mental illnesses.<sup>210</sup> However, the research did not conclude if poverty caused mental illnesses or mental illnesses caused poverty.<sup>211</sup> Consequently, the combination of poverty and mental illnesses prejudices increased the frequency that people with mental illnesses encountered discrimination.

Even though the demographics of mental illness can include the rate of occurrence and the realization of stigma, “the prevalence of mental illness” seems to remain the same within the population.<sup>212</sup> In 50 years of research, the United States had frequency rates that ranged between 15-30% for people with symptoms or behaviors of the psychiatric disorders.<sup>213</sup>

### **Factors Magnifying Stigma towards People Seeking Mental Health Services**

After determining that stigma towards people with mental illnesses exists, there are several factors that further magnify the negative effects from the public stigma and self-stigma.<sup>214</sup> Public stigma is “the reaction” to groups, such as people with psychiatric diagnoses and people accessing mental health services, by the “general public.”<sup>215</sup> Public stigma delineates the public perceptions and reactions to the following:

*Stereotype (in terms of public stigma):* “Negative belief about a group” derived from signals, such as, symptoms, skill deficits, appearance, and labels, of mental illness.<sup>216</sup>

*Prejudice (in terms of public stigma):* “Agreement with belief and/or negative emotional reaction” observed as attitudes of fear and anger of mental illness.<sup>217</sup>

*Discrimination (in terms of public stigma):* “Behavior response to prejudice” usually demarcated by hostile or harmful reactions actions to people diagnosed with psychiatric disorder or accessing mental health treatments.<sup>218</sup>

Public stigma magnifies the negative effects by reducing life opportunities, negatively encountering law enforcement, and reducing the available health care.<sup>219</sup>

One of the detrimental impacts of public stigma to people with mental illnesses or people seeking mental health services is the “loss of rightful life opportunities.”<sup>220</sup> The two basic necessities to obtain life goals are the following: 1. Obtaining competitive employment and 2.

Living independently in a safe and comfortable home.<sup>221</sup> Link and Phelan reported that when the “public labels human differences, ascribes meaning to these differences through stereotypes, and denies life opportunities.”<sup>222</sup> Life opportunities that are losses from stigmatization are housing and employment.<sup>223</sup> For people with mental illness, gaining meaningful employment and maintaining comfortable housing is often difficult because of public prejudices of employers and landlords.<sup>224</sup>

The second detrimental impact of public stigma to people with mental illnesses or people in need of mental health services is the potential for negative encounters with law enforcement.<sup>225</sup> The reaction of the criminal justice has also been influenced by public stigma resulting in the adverse notion that people with mental illnesses are criminals or that criminals potentially are people with undiagnosed mental illnesses.<sup>226</sup> As a result, people with mental illnesses tend to be sent to prison because of the stereotypes related to danger which imparts fear for public safety.<sup>227</sup> Moreover, the criminalization of mental illnesses has increased public fear and led to more severe sentencing and a reduction in mental health treatments.<sup>228</sup>

The third detrimental impact of public stigma to people with mental illnesses or people seeking mental health treatments is the reduction in health care resources.<sup>229</sup> Typically, people with mental illnesses are less likely to seek general health care, which includes both physical and mental health.<sup>230</sup> The reduction in health care resources is mostly the result of financial and insurance implications of people having mental illnesses and potentially reactions of health care providers not wanting to interact or provide services to people with mental illnesses.<sup>231</sup> Even though, stigma impacted responses of health care providers, there is not significant data to conclude that health care providers are intentionally withholding necessary services. However,

the practices of treatment providers appeared to have different variables and responses for people with mental illnesses.<sup>232</sup>

In addition to impacting the people with mental illnesses, stigma also impacts the family, treating providers, and the general public.<sup>233</sup> This type of stigma is known as associative or courtesy stigma.<sup>234</sup> Associative stigma results in prejudice and discrimination, causing negative impact or harm to groups of people or communities of people with mental illnesses. In the review of the research and personal accounts of stigma, many families reported that relatives have been deeply impacted by the prejudices and discrimination of people of mental illnesses.<sup>235</sup> The outcome of the associative stigma is that the family members become likely to mask or conceal the mental illnesses of a family member.<sup>236</sup> Even more concerning, the family may defer medically necessary treatment for psychiatric disorders or avoid the people with mental illnesses to evade the prejudices and discriminations of psychiatric diagnoses and mental health services.<sup>237</sup> Along with the family, associate stigma is responsible for deterring treatment providers from wanting to seek careers in mental health services, because of the labels and stereotypes of people with mental illnesses to be dangerous, incurable, and incompetent.<sup>238</sup> Moreover, potential treatment providers are paid less because of the general perceptions that mental health services do not produce outcomes or are invalid sciences.<sup>239</sup> In totality, associate stigma is responsible for harm to society as a whole, because the stigma promotes injustices, deprives society of resources, and instills fear.<sup>240</sup>

As stigma generates injustices and harms to the people with mental illnesses and those associated with mental illness, the people begin to accept the stereotypes and discriminations.<sup>241</sup> Consequently, the people with mental illnesses may have reduced “self-esteem, self-efficacy, and confidence in the future.”<sup>242</sup> Public stigma results in people with mental illness to alter personal

perceptions based on the stereotypes, prejudices, and discriminations; therefore, the following definitions in terms of self-stigma are important for understanding the responses by people with mental illnesses:

*Stereotype (in terms of self-stigma):* “Negative belief about self.”<sup>243</sup>

*Prejudice (in terms of self-stigma):* “Agreement with belief” causing “negative emotional reactions,” such as, low-esteem and low self-efficacy.”<sup>244</sup>

*Discrimination (in terms of self-stigma):* “Behavior response to prejudice” with results in the person not pursuing opportunities or participating in daily activities, such as “fails to pursue work and housing.”<sup>245</sup>

Self-stigma magnifies the negative impact experienced by people with mental illness by diminishing self-esteem and reducing accessing mental health services.<sup>246</sup> “People may opt to not seek treatment so they are not associated with this stigmatized group.”<sup>247</sup> The personal accounts of stigma reported that people seeking treatment do not want to be labeled a “mental patient.”<sup>248</sup>

## **Reduction in Utilization**

The research has supported that people with mental illnesses who meet the criteria for mental health services tend not to participate or do not complete recommended treatments or services based on the stigmatization of mental illnesses and negative perception of mental health treatment services.<sup>249</sup> However, the research has reported that evidence-based practices have significant success with reducing symptoms and supporting outcomes for “psychiatric symptoms, psychological distress, and life disabilities caused by mental illness.”<sup>250</sup> In the research conducted by Watson and Corrigan, the Epidemiological Catchment Area Study reported

that 30% of people that meet the criteria for mental health services based on general psychiatric disorders “never” access the mental health services.<sup>251</sup> Additionally, the research reported that only 60% of people with severe mental illnesses (schizophrenia, major depressive disorder, and manic depression) access mental health services, leaving approximately 40% of people without necessary treatment to alleviate the severe psychiatric symptoms and psychological distresses.<sup>252</sup> Similar to people with severe mental illness, scholarly research showed that people with substance use disorders also have high rates of not accessing and utilizing mental health services.<sup>253</sup> Astonishingly, research demonstrated that after people are admitted to inpatient facilities for intense mental health episodes only half of the patients will follow through with accessing outpatient mental health services.<sup>254</sup>

Since evidence-based practices and treatments are successful at remedying the symptoms and distresses of mental illnesses, there is justification to increase access to mental health services. There are two issues with access that impact the utilization of medically necessary mental health services: 1. Many never access mental health services and 2. Others have access but fail to adhere to services as prescribed.<sup>255</sup> The primary reason for the reduction in access and utilization is based on stigmatization. In association with stigma, the reduction in access and utilization can be explained with the “health belief models,” which are based on people being rational and making decisions to reduce perceived threats and increase perceived benefits.<sup>256</sup> With mental illnesses, the threats could be psychiatric disorder symptoms and benefits could be the reduction of psychiatric symptoms and psychological distresses.<sup>257</sup> The research of Watson and Corrigan concluded the following for health beliefs that negatively impact the access and utilization of the mental health services: deleterious effects of treatment, medication side effects, and unintended and negative effect that results from treatment.<sup>258</sup> Consequently, the health

beliefs models along with the appalling images of historical mental health treatments have perpetuated the stereotypes of mental illnesses and treatment and induced fear of mental health services; ultimately causing behaviors that withhold, avoid, segregate, and coerce.<sup>259</sup> The fear of mental health services and behaviors based on the negative health beliefs and stereotypes have instigated perceived injustices about practices of psychiatry and psychology. The most common perceived injustices throughout history and those that are currently present are related to safety, consent, and confidentiality. The perceived injustices are from the unintended effect of stigma and fear reducing access and utilization of mental health services.

By stereotyping and dehumanizing people with mental illnesses, society silently accepted cruelty and punishment to people with mental illness that included horrific practices of bloodletting, twirling them to unconsciousness, chaining them in dungeons, and throwing them into water.<sup>260</sup> The painful history towards people with mental illnesses has instilled images and stereotypes of mental health treatments that are not easily forgotten. The historical accounts of torture and abuse of people with mental illness continue the “sense of pessimism” for safe psychiatric treatments.<sup>261</sup> Despite the historical fact, evidence-based practices are producing positive outcomes for people with mental illnesses, the stereotype of historical psychiatric treatments compounded with the health beliefs, such as the deleterious and negative side effects of the current mental health services, prolongs the fear of mental health services throughout society.<sup>262</sup> The fear and questionable safety of mental health treatments compelled by stigmatization results in the reduction of access and compliance with contemporary mental health services that are safe and helping people overcome mental illnesses and restore rightful life opportunities.<sup>263</sup>

In addition to safety, there are stereotypes of people with mental illnesses that are causing society to adversely respond with unfair or unethical practices in regards to consent and confidentiality. The following stereotypes of people with mental illnesses are the root of loosened ethical standards in terms of mental health services:

1. People with mental illness are dangerous and should be avoided.
2. People with mental illnesses are to blame for their disabilities that cause weak character.
3. People with mental illnesses are incompetent and require authority to make decisions for them.
4. People are viewed as child-like and profit from parental figures to care for them.<sup>264</sup>

These perceptions of the people with mental illnesses have caused discriminatory actions by healthcare providers, families, and caregivers that lowered ethical practices.

Since many people with mental illnesses have been perceived and labeled as infantile and incompetent, mental health practitioners, families and caregivers tend to be less likely to allow people with mental illnesses to express autonomy and consent to health care treatments and services. Furthermore, throughout history, people with mental illness have been labeled incompetent and lost many legal rights to guardians. The stigma has permitted the guardians and mental health professionals to make decisions without involving or considering the people with mental illnesses themselves. Subsequently, people with mental illnesses have been coerced into treatments, such as, involuntarily admissions to state hospitals and sterilizations without consent.<sup>265</sup> The reluctance of society to allow people with mental illnesses to consent or refuse treatments has implanted fear; thus, the people are less likely to access or complete recommended mental health services without being forced.

Along with being coerced into mental health treatments, people with mental illnesses are often exposed to mental health professionals that are conducting experimentation for the evolving sciences of psychiatry, neurology, and psychology. Traditionally, mental health professionals in asylums had authority to conduct experiments to discover cures and treatments for mental disorders. The guardians and families banished people with mental illnesses to woods, asylums, or state hospitals which permitted the physicians and mental health professionals to obtain guardianship of the patients. Since the physicians and mental health professionals had guardianship, the patients were not given the opportunity to consent to the experimentation or clinical trials, as a result, people with mental illnesses were subjected to malaria fever and lobotomies without the rights to refuse. Moreover, even progressing into the 20<sup>th</sup> and 21<sup>st</sup> centuries with modern mental health services, people with mental illnesses can still be subjected to clinical trials to identify evidence-based practices without informed consent.<sup>266</sup> The contemporary clinical trials require consent, but often the clinical trials have been compromised because informed consent was not obtained and the people with mental illnesses did not receive complete or accurate details to the participation in the clinical trials. As the fear of being forced into clinical trials has remained, people with mental illnesses are less likely to access or continue in mental health treatments.

As a result of the stigmatization of mental illnesses and the fear of mental health services, people with mental illnesses have demanded for higher levels of confidentiality in the mental health diagnoses and treatments. However, mental health services traditionally had relaxed standards in protecting the diagnoses and treatment of mental health records. As a result, the general public was being told or was able to access information on people with mental illnesses causing the stigmatization to increase from the disclosures of the treatment records. As the

confidentiality requirements have become more stringent, there is still fear within the general public that there could be a data breach of mental health information even with the current protections. The fear of healthcare professionals disclosing mental health information persists, because the stigma has resulted in stigmatization that has negatively influenced basic rights, housing, and jobs. Ultimately, people do not seek or continue with mental health services if confidentiality is diminished.

## **Conclusion**

In conclusion, the fundamental components of stigma toward mental illnesses were evident as early as the Pneumatic Ages and still exist today. Even though, the actors and reasons for stigmatization may be changing, the primary components of labeling, stereotyping, and discrimination of people with mental illnesses can still result in loss of rightful life opportunities and cause significant reductions in the access and utilization of mental health services.<sup>267</sup> Furthermore, the stigmatization is not only directed at the mental health illnesses and diagnoses, but also has resulted in society and people with mental illnesses becoming fearful of the mental health professionals and contemporary psychiatric practices.<sup>268</sup> Based on the analysis of stigma, the stereotypes have elevated societal prejudices and labeled psychiatry as unethical, questioning basic principles of safety, consent, and confidentiality.<sup>269</sup> Overall, the major consequence to the stigma causes reductions in access and utilization of mental health services.

## **Chapter 4 – Reeducating and Changing Public Opinion to Reduce Stigma**

Based on reduced access and utilization of mental health services from stigmatization, there is justification to change the misinformation and opinion of society. However, for the change to be effective, the change can be introduced in different forms to impact the general public, which are institutional (laws and practices) change, societal change, and individual change.<sup>270</sup> Clark, et al. stated, “The model of change suggests that reductions in mental health illness stigma will likely occur to the extent that social norms, individual actions and beliefs, and institutional practices and policies converge to support acceptance of individuals with mental health problems and to the extent that the interventions are targeted at these multiple levels.”<sup>271</sup> Subsequently, there is a need to stimulate change in the societal perceptions towards people with mental illnesses, so people with mental illnesses will be empowered to access and utilize medically necessary services.

The purpose of Chapter 4 is to review the methods of change that can be beneficial to reducing stigma whether by education, contact, and protest. Each of methods of change in consideration of institutional, public, and individual stigma can influence the stereotypes and discriminations that people with mental illnesses encounter but the strategies can be more beneficial for different groups. Additionally, structural changes in mental health services of parity legislation and ethical and safety practice standards have helped to change stigma of mental illnesses and diminish fears of mental health treatments.

## **Methods of Change to Increase Utilization of Mental Health Services**

For over 50 years throughout the world, supporters and stakeholders have been investigating methods to introduce change to the society and individuals that will reduce stigma for mental illnesses and mental health treatments.<sup>272</sup> The research of the efforts has concluded that to induce change, the negative attitudes, fears, and misconceptions about mental illnesses and mental health services must be addressed by providing accurate information that diffuses the stigma and myths.<sup>273</sup> There are three topics to consider when trying to change attitudes and beliefs that cause stigma toward people with mental illnesses and mental health services. First, the change in attitudes and beliefs should consider the two types of stigma: public stigma (societal change) versus self-stigma (individual change).<sup>274</sup> Second, there are three methods of change, education, contact, and protest that deconstruct negative perceptions and stigmatization.<sup>275</sup> Third, the methods or interventions should be assessed to determine if there is change in the attitudes, affect, and behavior.<sup>276</sup>

To begin considering the concepts of changing stigma, there are two types of stigma, public-stigma and self-stigma, which have different stereotypes and negative perceptions. Subsequently, the reasons and needs to reduce stigma may be vary. Generally, public stigma is the societal misconceptions, stereotypes, and labels that lead to societal discriminations against people with mental illnesses and magnify fears with mental health services. Public stigma results in the general public denying people with mental illnesses basic rights such as working, living in communities, and accessing health care.<sup>277</sup> Additionally, public stigma can lead to self-stigma that causes additional disparities to people with mental illnesses.<sup>278</sup> People with mental illnesses begin to accept the stereotypes and prejudices of mental illness and fears of mental

health treatments as true causing people with mental illnesses to not seek or continue with mental health services.<sup>279</sup>

Consequently, the stigma and the negative attitudes of mental illnesses and mental health treatments need to change so that people with mental illnesses will access and utilize mental health services. Corrigan has defined three methods of change to reduce stigmatization. The first method of change is education. As a method to challenge stigma, education provides awareness of people with mental illnesses and available mental health services while replacing inaccurate stereotypes and prejudices with factual information.<sup>280</sup> Some strategies of change that are based on education and awareness interventions are “public service announcements, books, flyers, movies, videos, webpages, podcasts, and virtual reality.”<sup>281</sup> The benefits to using education and awareness as a method of change are that the costs are low and the potential scope of reception in society is wide.<sup>282</sup> However, education only has a limited effect on change, but has been proven to be most effective with children and adolescents as an early intervention of change.<sup>283</sup>

The second method of change is interpersonal contact with people with mental illnesses and mental health services.<sup>284</sup> Watson and Corrigan contents, “Contact has long been considered an effective means” for reducing stigma.<sup>285</sup> As a strategy to challenge stigma, the ideal contact is direct interaction with the stigmatized group.<sup>286</sup> Personal contact is the most effective method of change, because the people involved are able to learn similar interests, promote understanding, and foster relationships.<sup>287</sup> A few of the progressive strategies that focus on contact as a method of change include the following: advocacy groups, support programs, person-account videos, stakeholder workgroups, and mass media campaigns.<sup>288</sup> Even though contact is the most effective method change, the strategies tend to encompass less people and

require attention to the construction of the message in the education.<sup>289</sup> Overwhelmingly, the outcomes from personal contact are worth the additional resources to help reduce stigma towards people with mental illnesses.<sup>290</sup> Moreover, when individual contact and education are combined the interventions have further impact with the people involved and greater improvement in changing public stigma.<sup>291</sup>

The third method of change is protest or social activism against stereotypes, prejudices, and discrimination directed towards people with mental illnesses.<sup>292</sup> Watson and Corrigan reported that protest as a method of change “highlights the injustices” and shames people for disrespecting people with mental illnesses.<sup>293</sup> The forms of protest relevant to the stigma of mental illness and mental health treatments are “writing campaigns, phone calls, public denunciation, marches, sit-ins, and boycotts.”<sup>294</sup> While protest has benefits in “suppressing prejudices,”<sup>295</sup> there is a “rebound effect” that causes the “shamed” to become worse or reluctant to change.<sup>296</sup> However, protest does have value in reducing prejudices in the media and public settings, since the “shaming” of the prejudices become public and insight others to protest.<sup>297</sup>

The three methods of change have been successful at creating public awareness about mental illness and mental health services and educating the public about the stigma towards people with mental illnesses which is causing social change. Moreover, the three methods of change provide individual change to both the “stigmatized” and the “stigmatizer.”<sup>298</sup> However, the methods of change must also encourage individual change for the people with mental illness to access and utilize mental health services.<sup>299</sup> Based on self-stigma, even after stigma begins to be neutralized, people with mental illnesses have low self-esteems, conceal disabilities, avoid mental health services, and expect less from recovery.<sup>300</sup> Along with neutralizing the stigma towards mental illness and mental health treatments, people with mental illness needed to be

“empowered” to disclose the mental illnesses, overrule the harmful misconceptions about discrimination and treatment, and engage in mental health services.<sup>301 302</sup> To empower people with mental illness and reduce self-stigma, there must be multi-faceted methods of change that foster recovery, encourage self-directed care, and integrate support from the society.<sup>303</sup>

### **Approval of Legislation for Parity and Access to Increase Utilization**

In addition to social and individual change, there are policy and practice changes. One of the most applicable methods to counteract stigmatization with policy changes is to enact laws that deter prejudices and discriminations. In the United States, the largest institutional interference with mental health services was the result of group health plans and insurance companies limiting funding and access to mental health services. As a result, parity became the focus of lobbyists and legislatures to ensure that people with mental illness were not receiving less benefits and coverage than people with physical illnesses or disorders.

From research of the National Institute of Mental Health (NIMH) and similar Federal and State funded programs, the research has reported that mental health services have low rates of access and utilization.<sup>304</sup> In the United States, the NIMH has identified the leading disability for the Americans between the ages of 15 to 44 years old to be mental health disorders and less than half access mental health services.<sup>305</sup> Even more concerning to the United States is that people with mental health illness are less likely to access physical health care, which is significant because people with mental illnesses have life expectancies that are 25 years less than the average American population.<sup>306</sup> In an effort to treat the psychiatric symptoms and psychological distresses along with improving the overall health and quality of life for people with mental illnesses, there must be access to health care.<sup>307</sup> Throughout the history of health

care and mental illness in the United States, people have not accessed or utilized mental health services because of the stigmatization that created additional burdens and disparities and the fear of mental health treatments.<sup>308</sup> “The stigma [and fear] surrounding mental health causes millions of people to suffer by choosing not to get treatments.”<sup>309</sup> Additionally, the health care providers and payers, such as insurance and managed care companies, have been reluctant to provide and pay for certain mental health services based on the stigma and legitimacy of the professions.<sup>310</sup> The stigmatization of mental illness and legitimacy of the mental health professions have caused insurance companies to discredit mental health and substance use disorder benefits and implement discriminatory practices toward people with mental illnesses by creating barriers to mental health services by limiting access to mental health providers, raising premiums for mental health and substance coverage, and requiring lengthy pre-authorization process.<sup>311</sup>

In the United States, along with lower life expectancy rates, people with mental illnesses have higher costs of other physical health services, since the majority of people with severe mental illnesses have other co-morbidities, such as, heart disease, diabetes, and respiratory disease.<sup>312</sup> Since people with mental illnesses tend to have other physical health issues, the costs for medical care and insurance coverage can be high, and people with mental illnesses are burdened with high out of pocket expenses. Subsequently, mental health organizations, such as the American Psychiatric Association and the American Psychological Association, and other disability groups have lobbied to the Federal and State governments, particularly, the Substance Abuse and Mental Health Administration (SAMHSA) for the removal of discriminatory practices by payers and to stimulate access and utilization of mental health services. Based on the NIMH research specific to the burden and disparities for people with mental illnesses combined with substantial advancements and noteworthy outcomes with mental health services,

the mental health and disabilities organizations began demanding that the government assist with the burdens and disparities for people with mental illnesses in the health care systems.

Moreover, the burdens and disparities of people with mental illness extended beyond poor health and reduced the overall quality of life from losses in education, employment, and housing.

Subsequently, the Federal and State governments began to enact legislation to address the stigmatization and lack of access and utilization of health care services specific to people with mental illnesses.

Most of the information relayed from government proclamation was symbolical and educational and meant to encourage empathy for people with mental illness and to emphasize the effectiveness and quality of mental health services<sup>313</sup> However, the Federal government became authoritative with legislative codes demanding discriminatory practices to end and mandating that group health plans and insurance companies to cover mental health services the same as physical health services to stimulate access and utilization.<sup>314</sup> Some of the original legislation to address discrimination towards people with disabilities was the Education for All Handicapped Children Act (EAHCA) of 1975 and the Americans with Disabilities Act (ADA) of 1990. Subsequently, the original legislation that directly addressed discrimination towards mental illness and mental health services was the Mental Health Parity Act (MHPA) of 1996.<sup>315</sup> The MHPA was the first legislation to require the insurance companies to end discriminatory practices towards mental health services and imposed annual and life time limits comparable to the physical health coverage.<sup>316</sup> However, the MHPA did not address the availability of mental health services or additional insurance burdens placed on people with mental illnesses and was missing the protections for substance use disorders which is the most common psychiatric disorders.<sup>317</sup>

In 2008, the more comprehensive act, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of (MHPAEA) 2008 was enacted and included the following three goals of the Federal government specific to mental health services: expand protections over time for people with mental illnesses, include differential protections for subgroups with mental illnesses, and implement challenges within society to eliminate labeling of mental illness that undermines the government ability to support mental health services.<sup>318</sup> The MHPAEA restricted group health plans and insurance from providing “less favorable” benefits for mental health and substance abuse services in comparison to physical health services.<sup>319</sup> According to the Centers for Medicare and Medicaid Services (CMS), the following are the specific key requirements for group health plans or health insurance coverage based on the requirements in the MHPAEA. First, group health and insurance plans must include physical health benefits at the same levels of financial responsibilities, benefits coverage, and treatment limitations as mental health and substance use disorders.<sup>320</sup> Second, mental health and substance use disorders may not have additional out of pocket maximum compared to the physical health benefits.<sup>321</sup> Third, group health and insurance plans must have the same requirements for out of network providers of mental health and substance use disorders benefits as the physical health benefits.<sup>322</sup> Fourth, group health and insurance plans must have similar protocols for medical necessity determinations and denials for mental health and substance use disorders as the physical health benefits.<sup>323</sup>

In 2013, clarifications of the MHPAEA were provided in the final ruling on parity. The final ruling included additional requirements, such a benefits can be divided into classifications, plans are not required to measure benefits annually unless there are changes in benefit design, cost-sharing, or utilization that would change the financial obligations, no lifetime or annual

limits for “essential health benefits,” and preventive care should include mental health/substance use disorder counseling and screening similar to physical health.<sup>324</sup> Additionally, the final ruling on the MHPAEA addressed access and utilization issues for mental health and substance use disorders by restricting limitations based on medical necessity standards, utilization techniques, and prescription formulary designs that were more rigorous than the physical health and surgical limitations.<sup>325</sup> The final ruling states that financial obligations for mental health and substance use disorder benefits cannot be calculated separately from physical and surgical benefit.<sup>326</sup>

Even though, the main objective of the Patient Protection and Affordable Care Act (PPACA) of 2010 was to expand Medicaid services to millions of Americans without health coverage, the PPACA contained orders for Federal and State programs to follow the parity requirements. Moreover, the PPACA extended the requirements to smaller group health plans than originally identified in the MHPAEA.<sup>327</sup> Along with expanding the group health plans, the PPACA also included specific guidance for ensuring that the mental health/substance use disorder provider network was comparable to the physical health and surgical provider network. This inclusion of the PPACA was one of the important provisions to assist with the access and utilization by safeguarding people with mental health disorders from barriers to treatment and care.<sup>328</sup>

The legislation movements advocating for mental health services are beneficial for both increasing availability of mental health services while reeducating the general public on mental health illness and treatments to reduce stigmatization and encourage people with mental illnesses to seek treatments.<sup>329</sup> With coverage and treatment for people with mental illness and a general acceptability by society of parity, the new era of health care is improving the overall well-being of people affected by these conditions. Moreover, the additional resources in health care are

introducing new mental health treatments that are effective and safe. The Federal and State support of mental health services helps to legitimize the necessity and aids in reducing the stigma and fears of society since the value of mental and physical health disorders is equivalent.

### **Implementation of Ethical Practice and Patient Safety Standards**

As legislation is progressing and improving with increased access to mental health services, the presence of stigmatization towards mental health illnesses and pessimism of mental health services including psychiatry and psychology still lingered supporting the need for changes in practice.<sup>330</sup> Additionally, the tension between psychiatric and psychological interventions continued to delay the acceptance of the mental health services.<sup>331</sup> The division between psychiatric and psychological treatments was growing further apart; because psychiatrists have been unable to find the biological markings that cause mental health illnesses, and psychotherapists have to continually reinforce the therapies with limited empirical data.<sup>332</sup> The uncertainty of causes and outcomes of practices coupled with the horrific accounts of abuse and unethical practices has ensued fear and pessimism with the general public and produced anti-psychiatry movements. The fears and pessimism have caused reduction in the access and continuation of mental health services.<sup>333</sup> One of the most practical methods of change to reduce the stigma and fears in relation to mental health treatments is to validate psychiatry and psychotherapy with practice standards that establish ethical boundaries, incorporate humanist approaches with contemporary psychiatric practices, and develop professionalism for psychiatrists and psychotherapists.<sup>334</sup>

Between the reviews of the practitioners of evidence-based and value-based practices in psychiatry and psychotherapies, the progressions in mental health services are beginning to assist

people with mental illnesses to overcome symptoms, distresses, and disabilities.<sup>335</sup> Even though mental health services have evolved significantly, the quality and safety of psychiatry and psychotherapy has received continual scrutiny. In consideration of quality and safety, the American Psychiatric Association and American Psychological Association understood that other medical practices were able to improve quality and safety by introducing ethical principles in the practice standards and codes of ethics to circumvent the fears and pessimism within the sciences and treatments.<sup>336</sup>

In psychiatry, the consideration of ethical dilemmas and psychiatric ethics began to form around 1970. In 1977, the World Psychiatric Association introduced and accepted the first ethical code designed for psychiatrists.<sup>337</sup> The first code of ethics for psychiatry was to respond to the misuses of psychiatry, the aggressive public health models in Europe, and paternalistic approaches in the United States.<sup>338</sup> As psychiatry was advancing and psychiatrists were conducting additional clinical trials and aware of the need to reaffirm psychiatry and build the trust of the general public, the American Psychiatric Association incorporated basic medical ethics of care into psychiatry.<sup>339</sup> The framework for psychiatric ethics was constructed with the following four medical ethics principles: autonomy, non-maleficence, beneficence, and justice.<sup>340</sup>

The first ethical principle is respect for autonomy, which Beauchamp and Childress described as the principle that encourages people to decide on receiving health care and participating in research.<sup>341</sup> Respect for autonomy is responsible for incorporating more specific rules for health care practices, such as, telling the truth, respecting privacy, protecting confidential information, obtaining consent, and helping others make decisions when needed.<sup>342</sup> In psychiatry, the principle of autonomy has not always been accepted causing dilemmas that

resulted in the reduction of access and utilization. One of the most significant ethical dilemmas that ascended in mental health services was whether people with mental illnesses are capable to make autonomous decisions, such as refusing treatment.<sup>343</sup> Moreover, people with mental illnesses became fearful of the “manipulation or under-disclosure” of information that was presented or was not presented by the mental health providers.<sup>344</sup> People with mental illnesses are already in vulnerable positions to the providers of mental health services due to previously accepted practices of paternalism, however, lack of full disclosure and respect for autonomy only further discouraged people with mental illnesses from accessing and utilizing mental health services.<sup>345</sup> To counteract the ethical dilemmas, providers of mental health services had to accept and respect that people with mental illnesses had the “capacities and perspective” to be afforded autonomy by self-governing and voluntarily making decisions specifically to healthcare.

The second ethical principle is non-maleficence, which Beauchamp and Childress defined as the principle that “imposes an obligation not to inflict harm on others” and cited as “above all, do no harm.”<sup>346</sup> In medical ethics, this principle implies the following for providers of health care: “do not kill, do not cause pain, do not disable, and do not deprive of the pleasure.”<sup>347</sup> When this principle is considered with psychiatry and other mental health services, the general public continues to be cognizant of the horrific history of psychiatry that contradicted the essence of non-maleficence, such as, political interference that resulted in sterilization and death, harmful drugs, confinement and imprisonment, destructive treatments of the brain, and over-prescribing of psychotropic medication with no consideration of side effects.<sup>348</sup> The consideration of non-maleficence and psychiatry has been a “sensitive” topic, but must be

assimilated with psychiatric practice to reduce the fears of people with mental illnesses so that mental health services will be accessed and utilized.<sup>349</sup>

The third ethical principle is beneficence, which Beauchamp and Childress noted as the statement of mental health providers “to act for the benefit of others.”<sup>350</sup> Beneficence has been integrated into health care, because the well-being of the patients should be the main concern of providers.<sup>351</sup> Accordingly, the “positive benefits” of health care should be to seek medical diagnoses and remedy disorders while alleviating “harms” such as pain and suffering.<sup>352</sup> When considering beneficence with psychiatry and mental health services, the benefits and risks need to be contrasted to determine the amount of risk that should be accepted to receive benefit.<sup>353</sup> In most cases, the benefit of the patients should be the main concern of the health care providers; however, there have been times throughout history when the principle of beneficence was utilized for the benefit of society.<sup>354</sup> Subsequently, with psychiatry, many people with mental illnesses were harmed, isolated, and deprived, because the stigmatization of mental illnesses labeled people as dangerous to society. Therefore, the imprisonment or confinement was justified for the safety and benefit of society. Due to the threat of involuntary imprisonment and confinement, people were fearful of being diagnosed with mental disorder and avoided accessing and utilizing mental health services. However, as contemporary psychiatry advanced, the principle of beneficence has been associated with humanistic approaches that first value the well-being of people with mental illnesses while considering potential risks to society.

The fourth ethical principle is justice, which Beauchamp and Childress have defined as “fair, equitable, and appropriate treatment in light of what is due or owed to persons.”<sup>355</sup> Under the principle of distributive justice, the following values of giving each person an equitable share are measured according to need, effort, contribution, merit, and free-market exchanges.<sup>356</sup>

Consequently, the trends conflict with the different values of dividing the goods and services among society.<sup>357</sup> In health care, specifically for people with mental illnesses, the historical reviews have demonstrated that society has been burdened with the healthcare expenses and resources needed for people with mental illnesses. The societal burdening and stigmatization was magnified by people with mental illnesses being labeled as defectives, social wastes, and unhuman.<sup>358</sup> As a result, society justified the restrictions of resources, violations of personal rights, abuses in the name of science, and in some cases, the deaths of people with mental illnesses based on the societal benefits of reducing the costs and burdens.<sup>359</sup> As modern psychiatry progresses the ethical principle of justice is shifting to restore the values of mental health services to help those in need.<sup>360</sup> However, there is still a struggle between the distribution of the limited funding available for mental health services and physical health services, subsequently, providers are required to differentiate the variance in suffering between people.<sup>361</sup> The contemporary struggle to determine the just distribution has resulted in a decrease in access and utilization of mental health services; but, psychotropic medications and evidence based practices are proving to reduce the societal burden by reducing the per patient costs for mental illnesses.<sup>362</sup>

Similar to psychiatry, around 1990, psychotherapy implemented ethical principles and practice standards to advance the safety and quality of care and provide protections for people with mental illnesses.<sup>363</sup> Psychotherapy and ethics tend to have an “affinity” with each other since both are about the people and based on humanist approaches.<sup>364</sup> Even though humanist approaches are fundamental to psychotherapies and the harms appear to be less obvious, ethical principles are still necessary in psychotherapy since there are risks with consent and therapeutic relationships.<sup>365</sup> The American Psychological Association included the ethical principles in the

practice guide to provide education and guidance that will reduce the fears associated with mental health service and the stigmatization of mental illnesses.

In respect for autonomy, psychotherapy has a fundamental goal of assisting people with restored capacity so that the people can participate in informed consent for health care, therefore, should be a primary objective in most mental health treatment plans.<sup>366</sup> Additionally, respect for autonomy requires psychotherapists to ensure that treatment goals and interventions are effective at reducing psychiatric symptoms and psychological distresses and reducing risks from inadequate or unnecessary interventions.<sup>367</sup> In reviewing the second ethical principle of non-maleficence, psychotherapy must also respect the “do no harm” values. With psychotherapies, the risk of harm to people with mental illnesses comes from the trust and dependency instilled in the therapeutic relationship that makes the people with mental illnesses vulnerable to exploitation.<sup>368</sup> The integration of the non-maleficence into the contemporary psychotherapy practices assigns an “ethical duty” for psychotherapists to establish professional boundaries that decrease the risks of exploitation.<sup>369</sup> When considering the risks of psychotherapies, there is an obligation to consider the benefits of the psychotherapies. The benefits of psychotherapy have been scrutinized and many assumptions have questioned the legitimacy of psychotherapy, such as the following: psychotherapy does not provide any benefits, the benefits produced from psychotherapy would have happened anyway, psychotherapy is not a medical benefit, psychotherapy is harmful, and psychotherapy may have benefits but is not cost effective.<sup>370</sup> The negative connotations can be countered with the humanistic approaches of contemporary mental health services to combine modern psychiatry with psychotherapy that produce positive outcomes and data supporting that psychotherapies have significant benefits for people with mental illnesses.<sup>371</sup> Subsequently, the principle of beneficence is supported with psychotherapy.

Finally, the fourth ethical principle of justice, is helpful in ensuring that people with mental illnesses are safeguarded from providers withholding psychotherapies or providing ineffective and inadequate psychotherapies when psychiatric interventions should have been considered.<sup>372</sup> The principle of justice helps to restore the humanistic approach in mental health services while increasing respectability in the professionalism of psychotherapy.<sup>373</sup>

The ethical principles are essential to reducing the stigmatization and the fear of people with mental illnesses that are causing reductions in access and utilization of mental health services. The ethical principles are the foundations of the code of ethics and practice standards for mental health services, which continue to reestablish the professionalism of psychiatrists, psychotherapists, and neurologists in the health care realm.<sup>374</sup> The professionalism of the practices was under scrutiny in the United States because the laws and policies were violating basic rights for people with mental illnesses, clinical trials were increasing involuntary and unknown experimentation of people with mental illnesses, and new practices were unsupported by research and data were contrary to medical ethics.<sup>375</sup> Both the American Psychiatric Association and the American Psychological Association understood the importance of embracing professionalism within the practices. As a result, each of the professional organizations developed practice standards that addressed the four medical ethical principles, autonomy, non-maleficence, beneficence, and justice, while incorporating the three following factors of practice: “the role of therapist, the nature of mental disease, and the culture, religious, and even political environment in which patient and therapist coexist.”<sup>376</sup> The reliance on ethical and humanist ideology supports the professional organizations in “professing a vow of service to others,” and should allow stigma and fears to diminish and trust to be regained.<sup>377</sup>

## **Conclusion**

Conclusively, the implementation of practice standards that included medical ethics principles, humanistic approaches, modern medical models and evidence-based practices for psychiatry and psychology has increased the validity of the practices and decreased fears for people with mental illnesses.<sup>378</sup> Therefore, people with mental illnesses should be more willing to access and utilize the mental health services that are medically necessary to reduce psychiatric symptoms and psychological distresses. In closing, mental health services have obtained support through institutional changes in Federal and State policies and recognition for the practice changes that implemented professional and ethical standards to promote quality and safety;<sup>379</sup> however, the information must be relayed and understood by the general public to reduce stigmatization, diminish fears, and empower people with mental illnesses to access mental health services.<sup>380</sup>

## **Chapter 5 – Validation of Mental Health Awareness Campaigns and Programs**

According to the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (SAMHSA), there are different types of mental health campaigns and programs available on the website that have incorporated education, contact, and mass media to reduce stigma and increase access to mental health services.<sup>381</sup> The SAMHSA “Leading Change Report 2.0” reported strategic mental health campaigns and programs that will be developed between 2015 through 2018 based on the following mission: “SAMHSA is focused on leading change to better meet the behavioral health care needs of individuals, communities, and service providers. SAMHSA remains committed to adapting and responding to current and emerging challenges to advance the mission of [Health and Human Services] HHS and to promote and provide specialized resources to address the evolving needs of the behavioral health field.”<sup>382</sup> As a result many organizations have followed SAMHSA direction and developed mental health initiatives that concentrated on the reduction of stigma and discrimination towards people with mental illnesses.<sup>383</sup> Moreover, as the benefits of the campaigns and programs were realized, the mental health awareness expanded to include the promotion of mental health services to increase access and mental health services.

An example of private companies endorsing an anti-stigma campaign to reduce barriers and promote access to mental health services is the Stamp Out Stigma (SOS).<sup>384</sup> Currently, the SOS campaign is maintained by Association of Behavioral Health and Wellness and is endorsed by other insurance and managed care organizations, such as Aetna Behavioral Health, Beacon Health Options, Cenpatico, Cigna, MHN, New Directions Behavioral Health, and PerformCare. The mission of the SOS campaign is the following:

**Recognize** when you or your loved ones need help. Recognize the signs. Recognize when someone isn't getting the help they need. Recognize when stigma is creating a barrier to care. Recognize the high prevalence of mental illness.

**Reeducate** others to help them learn there is help and hope. Reeducate yourself and others on mental and emotional health. Reeducate yourself and others on how to find the path to recovery and that it is possible for all. Reeducate yourself on resources: What are your current benefits? Who can you talk to? What can you do?

**Reduce** stigma. Reduce hesitation to seeking care. Reduce misunderstandings. Reduce bullying and insensitivity.<sup>385</sup>

Additionally, the SOS campaign provides education of mental health illnesses and treatments, while including personal accounts from people with mental illnesses.<sup>386</sup> Finally, the SOS campaign has been effective, because there is a requested pledge to the “three R’s” of recognize, reeducate, and reduce stigma related to mental illnesses and substance use disorders. Finally, people who “take the pledge” are often rewarded with a bright green bracelet that includes the word recognize, reeducate, and reduce to remind of the pledge.<sup>387</sup>

Similar to the Association of Behavioral Health and Wellness with the SOS campaign, there have been many other initiatives to incorporate change interventions and strategies to reduce stigma and discriminations towards people with mental illnesses. Commonly, the themes of change utilizing intervention of education, contact, and protest are found in the mental health awareness campaigns and programs.<sup>388</sup> Moreover, positive responses with rewards and pledges are found to be helpful in the effectiveness of the campaigns and programs. This chapter will examine the different strategies of the mental health campaigns and programs, determine the effectiveness of the campaigns and programs, and evaluate improvements and themes for future

mental health campaigns and programs that can help to reduce stigma towards people with mental illnesses while incorporating the promotion of access and utilization of mental health services.

### **Anti-Stigma Campaigns and Trainings**

Based on the barriers and discriminations towards people with mental health illnesses, many mental health organization both professional and government-funded began to campaign for the general public to change the labeling and stereotyping that causes stigma and fear.<sup>389</sup> Collins, et al. noted that contact, education, and protest are the “core elements” of the anti-stigma campaigns and “mental illness stigma and discrimination reduction programs.”<sup>390</sup> The most common interventions that are utilized in anti-stigma campaigns are trainings, mass media campaigns, and broad multi-faceted programs.<sup>391</sup> The main purpose of most of the interventions is to replace misconceptions about mental illness with factual information that promotes positive images and responses for the people with mental illnesses.<sup>392</sup> Each of the different interventions, whether training or mass media strategies, have goals to reduce discriminations against people with mental illnesses to increase access to mental health services and promote recovery.

Predominantly, for smaller targeted audiences, the anti-stigma interventions and strategies have been designed as training interventions with educational and contact strategies.<sup>393</sup> These strategies are prevalent throughout the anti-stigma campaigns, because research, such as Corrigan, et al., has reported that both education and contact have positive influence on reducing stigma towards people with mental illnesses.<sup>394</sup> The training interventions for anti-stigma campaigns have been modeled to provide factual information about mental illnesses and mental

health treatments to specific groups and audiences, such as “employers, landlords, criminal justice, health care providers, policymakers, and the media.”<sup>395</sup> Some of the anti-stigma campaigns have been completely educational, while other campaigns have incorporated contact elements into the training interventions.<sup>396</sup>

In consideration of training interventions with education strategies, the efforts are to educate specific groups or audiences with truthful information that helps reduce the stereotypes within groups that directly impact people with mental illnesses. Often, the education is delivered to professional groups, such as school teachers or police officers that will interact and could influence societal outcomes for people with mental illnesses.<sup>397</sup> Accordingly, the training is provided to the targeted groups to eliminate labeling that people with mental illnesses results in stereotypes such as being incapable of learning or posing additional threats to the public. The training interventions are important for redefining the responses of the professionals and societal groups to people with mental illnesses so that disparities and discriminations are eliminated or reduced.

In Minnesota, the Mental Health Crisis Response Institute (MHCRI) is a crisis and stigma and discrimination reduction program with the following mission statement, “to provide the best quality training available to first responders so they will be able to safely respond to mental health crisis at any time and will work with the community to resolve each situation in manner that shows concern for the person in crisis’ wellbeing.”<sup>398</sup> In the program, there are goals that are specific to promoting patient-centered training and care focused on prevention, management, recovery, and wellness while also reducing restraints and seclusions during crisis. The MHCRI relies on training strategies that focus on re-educating first responders to accurate and factual information specific to mental health crises. The MHCRI describes the training as follows, “We

stress the need to respect, not be judgmental, not to make assumptions about the person in crisis, and to use the skills the students learn and practice in the class for the responder's safety, the person in crisis' safety and the community's safety.”<sup>399</sup> Subsequently, the MHCRI claims that 98% of people that participate in the program report de-escalation when responding to mental health crises.<sup>400</sup> The MHCRI is a good example of a stigma and discrimination educational program, because the training strategies are aimed at a targeted population (first responders) to reduce disparities (restraints and criminal arrests) against people with mental illnesses. This program may also be beneficial at increasing access to mental health services, since first responders are able to direct people with mental illnesses to crisis and mental health treatment providers.

Another type of training intervention that is often paired with educational strategies is contact strategies.<sup>401</sup> Corrigan, et al. reported, contact strategies are more effective for adults, and even though video contact is effective, face-to-face contact is the most effective strategy for reducing stigma among adults.<sup>402</sup> In training strategies that involve contact with people with mental illnesses, there are personal accounts or stories that help to reduce stigma by personal interactions that allow the targeted audiences to relate to and/or interact with people that have mental illnesses.<sup>403</sup> The contact strategies allow for the targeted audiences to have personal experiences from the contact with the people that have mental illnesses. The personal experiences override the previous misconceptions and reduce discriminations toward people with mental illnesses and allow for people with mental illness to self-disclose.<sup>404</sup>

In the United Kingdom, the YoungMinds campaign uses the combination of contact and education strategies to reduce the stigma and discrimination that students with mental illnesses encounter within the school and educational settings. The mission of the YoungMinds is to

“improve the emotional resilience and mental health of children and young people throughout the UK by informing and actively engaging with children, young people, parents, policymakers and professionals.”<sup>405</sup> The YoungMinds program utilizes contact strategies that target student and teacher populations that can directly impact the social and educational experiences for students with mental illnesses. For the anti-stigma initiatives within the schools, the YoungMinds organization provides resources to teachers and schools, while also engaging students within the schools to tell their stories of mental illnesses.<sup>406</sup> The YoungMinds partnered with “Time to Change” Campaign, so that teachers and school professionals could have contact with students with mental illnesses and hear the personal accounts of stresses and disparities that these students are encountering in the school settings.<sup>407</sup> Along with contact through personal account videos, the students with mental illnesses and teachers were able to blog their experiences and responses to the experiences, which permitted interaction and direct contact. The YoungMinds program is a good example of stigma and training programs for teachers and schools professionals that involve training interventions that include both educational and contact strategies.

Along with strategies of training interventions, the YoungMinds program in the United Kingdom includes mass media and multi-faceted interventions. Similar to the objectives of training interventions to reduce stigma and discrimination towards people with mental illness, there are mass media and multi-faceted interventions that focus on the reduction of stigma and discrimination that target broad audiences instead of smaller groups. Additionally, the large anti-stigma campaigns and multi-faceted interventions have long-term and large-scale objectives that employ protest strategies (educating media and advertisements), direct contact (social events and fundraising campaigns), and educational material (internet webpages and pamphlets).<sup>408</sup>

In the United States, one of the largest advocacy groups that relies on mass media and multi-faceted interventions to advocate for people with mental illnesses is the National Alliance in Mental Illness (NAMI).<sup>409</sup> NAMI objective are the following:

**We educate.** Offered in thousands of communities across America through our NAMI State Organizations and NAMI Affiliates, our education programs ensure hundreds of thousands of families, individuals and educators get the support and information they need.

**We advocate.** NAMI shapes the national public policy landscape for people with mental illness and their families and provides grassroots volunteer leaders with the tools, resources and skills necessary to save mental health in all states.

**We listen.** Our toll-free NAMI HelpLine allows us to respond personally to hundreds of thousands of requests each year, providing free referral, information and support—a much-needed lifeline for many.

**We lead.** Public awareness events and activities, including Mental Illness Awareness Week (MIAW), NAMIWalks and other efforts, successfully combat stigma and encourage understanding. NAMI works with reporters on a daily basis to make sure our country understands how important mental health is.<sup>410</sup>

The efforts of NAMI have been so successful and recognized that the organization received over \$10 million from contributions, donations, registrations, dues, and grants to support the organization and mental health programs.<sup>411</sup> The NAMI is a good example of how large and expansive anti-stigma initiatives and programs can become when the programs are effective and organized well.

The results of the small-scale trainings may not be as evident as the multi-faceted campaigns and programs, such as NAMI, for demonstrating effectiveness; however, the campaigns and programs have demonstrated changes in the attitudes, affect, and behavior.<sup>412</sup> Subsequently, the anti-stigma campaigns and program regardless of size have a diminishing effect on stigma and discrimination; however, the evidence and research had not been fully developed to support these diminishing accounts. Correspondingly, the changes in attitudes, affect, and behavior do validate the justification to endorse more mental health and anti-stigma campaigns and programs while expanding evaluations and assessments to determine the actual reductions in stigma and discrimination.<sup>413</sup>

### **Compounding Mental Health Campaigns and Programs to Address Stigma and Fears of Mental Health Services**

In the reduction of stigma and discrimination towards people with mental illnesses, there is an eventual goal to encourage people with mental illnesses to access and utilize mental health services. The mental health awareness campaigns and programs targeting stigma can also be beneficial in encouraging people with mental illnesses to access mental health services. The anti-stigma campaigns have impacted attitudes, affect, and behavior towards people with mental illnesses, which appears to reduce public stigma and self-stigma. With the reduction in overall stigma, people with mental illnesses should be more likely to access mental health services. However, the general public must be informed on the diagnosing and treating of mental illnesses with mental health services that are effective and have incorporated safe and ethical practice standards. In the previous reviews of barriers to treatment, the fears toward mental health services based on the horrific abuses and treatments of people with mental illness still resonates

and reduces people with mental illnesses from accessing mental health services. Additionally, the barriers present miscommunication about availability and access to mental health services. When mental health awareness campaigns and programs provide factual and relevant information on the mental health services, such as diagnosing, treating, and recovery, people with mental health illnesses can be less fearful and more knowledgeable of mental health services. Subsequently, by compounding the mental health awareness campaigns and programs with anti-stigma training and awareness of mental health services, the access and utilization should increase because the idea of mental health services is less mysterious and terrifying to people with mental illnesses.

Correspondingly, SAMHSA has reported three areas to inform the general public of the importance of mental health treatments, which are mental illnesses, substance use disorders, and treatment and recovery supports.<sup>414</sup> For mental illnesses, the general public should be informed of the various diagnoses, the prevalence of the mental illnesses throughout the populations, noticeable symptoms and behaviors, and treatments that have been proven effective and promote recovery.<sup>415</sup> Likewise, the general public should be educated on the same type of information for substance use disorders.<sup>416 417</sup> The information presented about the mental illnesses and substance use disorders should be respectful and encourage those with symptoms or similarities to understand the importance that mental health services may have in reducing psychiatric disorders and psychological distresses. The third topic that should be covered should discuss the actual treatments and recovery supports that are part of the continuum of mental illness and substance use disorder services.<sup>418</sup> When educating the general public on treatments and recovery supports, the following topics should be emphasized: safe and ethical practice standards, evidenced-based and promising practices that are supporting recovery, descriptions of

the types of practices and practitioners, and information to guide people to find help and access mental health services.<sup>419</sup>

Respectively, SAMHSA has strategic initiatives that compound objectives that include awareness and access to mental health services, which are the following: “increase awareness and understanding of mental and substance use disorder, promote emotional health and wellness, address the prevention of substance abuse and mental illness, increase access to effective treatment, and support recover.”<sup>420</sup> The initiatives of SAMHSA demonstrate the need and justification to include interventions into the mental health awareness campaigns and programs that denote modern mental health services that are as less mysterious and terrifying. By providing factual information to the general public about the diagnosing of mental illnesses and substance abuse disorders and the corresponding mental health treatments, people with mental illnesses can become aware of the importance of mental health services.<sup>421</sup> Moreover, the people with mental illnesses can be educated about the “innovation and practice improvements” that support evidence-based practices that are supporting people with mental illnesses to recovery.<sup>422</sup> Subsequently, by compounding the information about diagnosing and treating mental illnesses with anti-stigma campaigns and programs, people with mental illnesses can be knowledgeable on the effective mental health services along with how to access them.

The SAMHSA and NAMI programs are both examples that have combined education, contact, and protest to “suppress stereotypes” and stigma while also providing important information on mental health services that reduces fears and increases access.<sup>423</sup> In reviewing the SAMHSA and NAMI websites, there are links and information that include educational strategies about knowing the warning signs, the different types of mental health conditions, the types of treatments and providers, and where to access help and treatments.<sup>424</sup> Once the stigma

of mental illness is reduced, the general public needs this additional information to know when and how to access mental health services. Moreover, the most beneficial part of the SAMHSA and NAMI programs is the incorporation of contact strategies that allow the general public and people with mental illnesses to access mental health treatments and providers. Both SAMHSA and NAMI have databases that allow anyone to search for providers and treatment services for mental health illnesses and crises. Furthermore, SAMHSA and NAMI provide hotlines for the general public and people with mental illnesses to contact mental health providers through telephone hotlines and helplines. By offering contact with mental health services, through the hotline the general public including people with mental illnesses may be more likely to access services if they can talk to someone that will reduce fears and provide factual information about mental health services, such as, psychotherapies, support services, and medications.<sup>425</sup>

Even though, there are positive increases in the access and utilization of mental health services, the United States still has many people with mental illnesses that are not accessing services. As reported previously, there are approximately 10 million American that have mental health symptoms or illnesses and are not accessing mental health services. With such high numbers people without treatments, there is justification to continue with the compounded mental health awareness that reduces stigma and discrimination towards people with mental illnesses and promotes access to mental health services.

### **Mitigating Stigma and Increasing Access with Additional Mental Health Awareness**

SAMHSA and NAMI are large organizations that have compounded, multi-faceted campaigns and programs that are reducing stigma and promoting mental health services, however, there continues to be a justification for other organizations to employ similar mental

health awareness campaigns and trainings. SAMHSA's website and resources have compounded all of the elements to combatting the stigma of mental illnesses and the fear of mental health services by including examples of programs, initiatives, resources, and campaigns. Subsequently, SAMHSA has provided guidance to implementing a mental health awareness campaigns and programs that will be effective at reducing stigma called "Developing a Stigma Reduction Initiative."<sup>426</sup>

In the "Developing a Stigma Reduction Initiative" guide, there are tools that are helpful to local, regional, and statewide programs that are specific to stigma and discrimination reduction. Additionally, the same tools are effective when compounding the initiatives with mental health awareness to promote access to mental health services. SAMHSA reported that there are two main components that will make the campaign or program effective is people and financial resources.<sup>427</sup> Moreover similar to the research of Collins, et al. and Corrigan, et al., there are three social marketing strategies of public education, direct contact with consumers and providers of mental health services, and rewards for positive portrayals of or involvements with people with mental illnesses.<sup>428</sup> Again, these strategies are consistent with previous research for stimulating change; however, adding rewards and promotions encourages positive responses from the general public for participating or supporting the initiatives.

Along with selecting the strategies for the campaign or program, when compounding stigma reduction of mental illnesses and access promotion for mental health services, the recommendation in the SAMHSA anti-stigma marketing plan can be adjusted with the following to include references and strategies to access and the promotion of mental health services:

1. Complete an assessment of the goals of the mental health awareness campaign or program that considers anti-stigma strategies with promotion of access strategies.<sup>429</sup>

2. Identify the audience, whether the mental health awareness campaign or program will speak to the people with mental illnesses, the general public, or a target-audience.<sup>430</sup>
3. Develop a message, there should be a message that corresponds with the goals and objectives of the mental health awareness campaign or program, which can include access to mental health services.<sup>431</sup>
4. Select communication channels and methods that will reach the audiences, such as pamphlets or websites that will discuss stigma or provide information about accessing mental health services.<sup>432</sup>
5. Choose activities and materials that will support the education of the mental health awareness campaign or program.<sup>433</sup>
6. Establish partnerships with groups, organizations, businesses that can aid with the people and financial resources needed for the mental health awareness campaign or program along with mental health providers and agencies that can assist with the promotion of mental health services.<sup>434</sup>
7. Implement the plan for the mental health awareness campaign or program including information and/contact about mental illnesses and mental health services.<sup>435</sup>
8. Evaluate and make adjustments to the mental health awareness campaign or program when needed, such as updating new information on mental illnesses and advancements in mental health services.<sup>436</sup>

By adjusting the marketing plan slightly, the guide is also useful for designing mental health campaigns and programs that compound stigma and discrimination reduction while promoting increased access and utilization of mental health services.

Even though SAMHSA and other professional and government funded initiatives have been successful at implementing compounded mental health awareness campaigns and programs and there is a need for addition campaigns and programs, the outcomes and evaluation has been limited. The programs need to be continually updated and include an evaluation process. There is clear evidence that the anti-stigma campaigns are changing attitudes, affect, and behavior, but with additional research, we want to be able to prove that the anti-stigma campaigns are reducing stigma and improving access.<sup>437</sup> The “Developing a Stigma Reduction Initiative” guide does include resources for evaluating the effectiveness of the mental health awareness campaign or program. However, there is needed research in this area. Along with outcomes from the mental health awareness campaigns and programs, there are future considerations that can reduce stigma and discrimination along with eliminating fears to increase access and utilization of mental health services.

## **Conclusion**

The Epidemiologic Catchment Area (ECA) Study reported that less than 30% people with mental illnesses symptoms seek mental health service and approximately 40% of people diagnosed with severe mental illnesses, such as schizophrenia, are not actively in treatment.<sup>438</sup> The underutilization of mental health services is astonishing and raises questions of social responsibility for the general public, professional organizations, advocacy groups, and Federal and State governments. The social responsibility is derived from the acceptance by society that people with mental illnesses are recognized as vulnerable persons.<sup>439</sup> Beauchamp and Childress have defined the persons that are “incapable of protecting their own interest because of sickness, debilitation, mental illness, immaturity, cognitive impairment, and the like” as vulnerable.<sup>440</sup>

Based on the moral status of the United States and throughout the world, there are justifications for social obligations and responsibilities, because the vulnerable persons are susceptible to harmful mistreatments from diminished decision-making capacity and socioeconomically impoverishments.<sup>441</sup> Moreover, societal prejudices and discriminations result in additional disparities to vulnerable populations. As a result of the mistreatments and discrimination, there are sympathetic and unprejudiced responses from society based on the moral status to accept social responsibility to mitigate disparities to the vulnerable populations.<sup>442</sup> The mental health awareness campaigns and programs have been at the forefront of the societal responses to the prejudices and discriminations towards people with mental illnesses and the underutilization of mental health services. As government and private organizations continue to implement anti-stigma campaigns and mental health awareness campaigns and programs, SAMHSA should continue to support with evaluations and resources that assist people with mental illnesses to access and utilize mental health services.

Subsequently, there have been other institutional changes that have been beneficial for people with mental illnesses, such as the professional and ethical standards in the psychiatry and psychotherapy practices. Additionally, considerations in institutional changes and societal responsibilities specific to community mental health, tragic and crisis events, and regulations for access and funding of mental health services can be compounded into the mental health awareness campaigns and programs to increase public knowledge and reduce vulnerabilities or people with mental illnesses. Ultimately, as the changes are implemented, knowledge is disseminated, and stigma is reduced, people with mental illnesses are more likely to access mental health services.

## Chapter 6 – Social Obligations

Since mental health awareness campaigns and programs are providing positive outcomes and are justifiable societal responses based on common morality to promote recovery for people with mental illnesses, there are additional social obligations and considerations that may be compounded into the campaigns to assist with reducing stigma and promoting recovery and well-being for people with mental illnesses. The social obligations that should be considered in the efforts of stigma reduction and access improvements for people of mental illnesses are the following: community mental health integration models, considerations of tragic events from mental illnesses, such as crisis planning, community interventions, and mass media coverage, and finally future policy and government funding of mental health services.

As these new institutional and structural changes are considered, the need to reduce stigma and eliminate misconceptions and stereotypes of people with mental illnesses becomes endlessly important, because societal obligations can extend beyond the needs of vulnerable populations when there are threats to the general public or communities. Since people with mental illnesses have a history of being stereotyped as dangerous, deviant, and criminal, the societal responses occasionally favor the protections and common goods of the community over the rights and liberties for people with mental illnesses.<sup>443</sup> The ethical dilemma of the societal obligations between the protections and common goods of the community versus the rights and liberties of people with mental illnesses (vulnerable persons), is contingent on the moral theories engaged to legitimize societal responses.<sup>444</sup>

Common morality has social responsibilities that include “prevent evil or harm from occurring,” “rescues persons in danger,” “nurture the growing and dependent, and “do not punish

the innocent” that are often applied to the vulnerable persons.<sup>445</sup> However, there are different moral theories that often compete and are reflected in the societal responses. The process for determining the “principles, rules, professional obligations, and rights” that should dominate the societal responses is defined by Beauchamp and Childress as the weighing and balancing process.<sup>446</sup> When societal obligations are considered, the rights and liberties of vulnerable persons are weighed and balanced against the protections and common goods of the community.<sup>447</sup> A societal obligation based on the rights theory would include “statements of rights that include life, liberty, expression, and property.”<sup>448</sup> Even though, obligations are not the equivalent of rights; typically, the societal obligations are trying to protect against disparities, such as “oppression, unequal treatment, intolerance, arbitrary invasion of privacy, and the like.”<sup>449</sup> For people with mental illness, the societal obligations based on the common morality and rights theory has been based on restoring human dignity and encouraging recovery to counteract the historic prejudices and discriminations that inflicted additional harms and punishments on the innocent.<sup>450</sup>

Conversely, common morality has instilled societal obligations that protect the general public and community. This competing moral theory is known as communitarianism, described by Beauchamp and Childress as the theory that considers “communal values, common good, social goods, traditional practices, and cooperative virtues” as primary principles in determining societal responses.<sup>451</sup> As a consequence of communitarianism, the sympathetic considerations to people with mental illnesses are often diminished based on stigma and overgeneralizations that invoke safety concerns for the community.<sup>452</sup> Subsequently, the societal obligations and common morality transitions to protecting the community from the vulnerable persons, which

has historically resulted in people with mental illnesses being confined to prisons or coerced into involuntary treatments.

The objective of Chapter 6 is to consider the societal responses to people with mental illnesses and the impact of the new intuitional and structural changes introduced by Federal and State governments for access to health care in general, but has significant implications for mental health services. Since stigma has been weakening and evidence-based mental health services are promoting recovery for people with mental illnesses, the societal obligations tend to concentrate on stimulating access and utilization of mental health services within the community. However, tragic events and mass media portrayals of people with mental illnesses as dangerous criminals continue to cause tension in the balancing of societal obligations. The first social obligation is to consider the movement to return people with severe mental illnesses to the community with the implementation of community health centers that integrate physical and mental health services.<sup>453</sup> Secondly, for the community mental health models to be successful, there must be methods to introduce the communities to crisis and safety plans to divert harm and tragic events without increasing stigma towards people with mental illnesses.<sup>454</sup> Finally, the Affordable Care Act and new Federal policies continue to justify the obligation to equalize mental and physical health and expand access of mental health services to people in the United States by including parity in funding and availability. Ultimately, if the mental health awareness campaigns and programs reduce and recognize these institutional and structural changes, then common morality would continue to rationalize the promotion of recovery and well-being of people with mental illness to ensure the rights of the individuals and protect the goods of the community.

## **Community Mental Health Models**

In consideration of contemporary mental health services, including philosophies of post-psychiatry, there are movements in process to transition people with mental illnesses from state mental hospitals to community settings with outpatient mental health services.<sup>455</sup> Many people with mental illnesses function and live within communities without many disruptions; however, these newer movements could put people with severe mental illnesses that have been dependent on inpatient services for years into communities without the same level of assistance.

Complications and increased fears can occur when people with severe mental illnesses are taken out of mental hospitals and placed into the general public.<sup>456</sup> This section will analyze the ethical concerns relating to the effect that releasing people from mental hospitals to the general public could increase stigmatization; however, with comprehensive mental health awareness campaigns and programs can be reduced for people with mental illnesses and awareness of effective and ethical practices will promote utilization of mental health services.<sup>457</sup>

The concepts of community mental health models are derived from the premise that all people deserved the opportunity to work and live within the community.<sup>458</sup> Moreover, around 1945, the United States began to encounter significant financial burdens from the mental hospital daily census that was exceeding 430,000 patients, and of those patients, 85,000 were first-time admissions.<sup>459</sup> Furthermore, psychotropic pharmaceuticals were beginning to provide clinical evidence of positive outcomes. As a result, the United States began the deinstitutionalization of mental health patients, and people with mental illnesses were returned to communities with community-based mental health services that relied on the psychotropic pharmaceuticals.<sup>460</sup> This idea of community-based mental health services for patients with serious mental illnesses legally came to fruition when the Federal government introduced the Community Mental Health

Centers Act of 1963, which relied on the ideology that patients would return to homes in the community with sympathetic supports from the community mental health center (CMHC).<sup>461</sup> Additionally, in 1965, Medicare and Medicaid were introduced, and in 1970s, Social Security Insurance expanded, resulting in the governmental need to proceed with the deinstitutionalization since the government programs would bear the largest burden of the expenses for these vulnerable populations.<sup>462</sup>

As a result of deinstitutionalization and funding, the mental health services were significantly different, and primary care needs became the responsibility of the caregivers or the people with serious mental illnesses. First, the mental health services were in an ambulatory setting such as the CMHCs, and only people with serious mental illnesses that were in acute episodes of symptoms that exposed the patients or the community at risk were placed in inpatient psychiatric care.<sup>463</sup> In the community, the people with serious mental illnesses were now responsible for basic living and support needs, such as “housing, nutrition, daily activities, and supervision.”<sup>464</sup> Consequently, people with mental illnesses became homeless, exposed to illicit drug and alcohol use, involved in disorderly conduct and minor criminal activities, and experienced decomposition in physical health conditions.<sup>465</sup> For the community mental health models to be effective and support people with serious mental illnesses in the community, the patterns of physical and mental health services had to adjust.

The CMHC introduced community-based interventions, such as mobile medication monitoring and case management, which had the following therapeutic objectives: “illness and medication education, substance abuse screening and treatment, family involvement, attention to stable living, linkage to needed social and rehabilitate services, and supported employment.”<sup>466</sup> Moreover, the 2003 New Freedom Commission on Mental Health introduced the following

recommendations to maintain people with serious mental illness in the community-based treatments: mental health must be included in health care, treatment should be patient and family centered and driven, disparities in mental health care should be mitigated, early screening and interventions are required, research should be increased, and new technology such as telemedicine should be expanded.<sup>467</sup> With the recommendations and redesign of community-based mental health treatments, treatment interventions and objectives were aiming for people with mental illnesses to experience “recovery” instead of previous attempts to cure mental illness symptoms since even modern psychiatry was unable to provide cures for serious mental illnesses.<sup>468</sup> Respectively, Mechanic and Grob defined recovery as “participating to the fullest extent possible in the community despite one’s impairments.”<sup>469</sup>

The new community-based model of mental health services does promote individual rights and liberties for people with mental illnesses. However, even though people with serious mental illnesses have a restored sense of community, there is still a societal obligation to provide support to the people with mental illnesses so they maintain stability, health, and freedom within the community. As a result, the financial burden and over-reliance on confinement to psychiatric institutions was resolved; however, people with serious mental illnesses were prone to other vulnerabilities in the communities, such as poor health conditions, homelessness, and criminal involvement. Accordingly, the societal obligations transitioned to comprehensive, recovery-based, and community-based services, such medication management and case management and integration of physical and mental health services.

With the emphasis on community-based services and integration of physical and mental health services, the mental health awareness campaigns and programs should include themes that reduce the overgeneralizations of people with serious mental illnesses in the community. With

reports of poor health conditions, homelessness, and criminal involvement, the community could ascertain general threats and additional burdens that would increase the fear and stigma towards people with mental illnesses. The mental health awareness campaigns and programs could consider themes and messages that convey sympathetic and supportive responses to people with serious mental illnesses living and interacting in the community. Moreover, the mental health awareness campaigns and programs should compound resources for the new comprehensive services available for people with serious mental illnesses, so that people struggling to maintain in the community may have the knowledge to seek these mental health services.

### **Prevention of Harm and Tragic Events**

As modern mental health services advance and more people with mental illnesses are living within the communities, there are potentials for harm and tragic events and other community concerns.<sup>470</sup> Subsequently, there is still a public fear of people with mental illnesses that perpetuates the stigma and increases violent interactions for people with mental illnesses.<sup>471</sup> The fears of the community are recognized in the community from tragic events involving mass violence and killings. Furthermore, the mass media and broadcasts have induced over-sensationalized portrayals of people with serious mental illnesses as all being crazed, violent murderers. Even though there is a correlation between people with serious mental illnesses and violence, there is not enough evidence to support that mental disorders cause people to be violent and murder.<sup>472</sup> There is evidence to support that people with mental illness can have episodes of unpredictable behavior when compliance and monitoring of treatment is compromised or there is decomposition, which triggers more violent responses for people with mental illnesses.<sup>473</sup> However, based on the media coverage of the few people with mental

illnesses that did pose significant risks to the general public, the violent actions of a few have been transposed as an overgeneralization by society to the entire population of people with serious mental illnesses.

Recently, President Barack Obama's commitment to the final ruling of Mental Health Parity and Addiction Equity Act of (MHPAEA) and Patient Protection and Affordable Care Act (PPACA) demonstrated mental health awareness that can address issues of safety while also preventing further stigmatization of people with mental illnesses. Additionally, President Obama started anti-stigma efforts through other public policies and campaigns based on tragic events, such as the "Now is The Time" plan for reductions in gun violence and other violent incidents related to mental illnesses. In the President Obama's plan, the mass shootings that occurred in Newton, Tucson, Aurora, and Virginia Tech are addressed by inferring that these incidents may have been avoided or deescalated with extending additional mental health and crisis services for the children and young adults.<sup>474</sup> Subsequently, President Obama's plan is a mental health awareness and access program that includes early intervention and treatment for young people, "Mental Health First Aid" training for teachers, technical assistance for mental health professional on integrating mental health services with schools, and including provisions in the PPACA to ensure that insurance and health plans provide the same access and available of mental health services as physical health services.<sup>475</sup>

To support the institutional changes that attempt to counterbalance violence and mental illnesses, there are societal obligations to support increased access and utilization of mental health services available to the people with mental illnesses within the communities.<sup>476</sup> However, there is still consideration to be given to prevent harm and tragic events. Again, the mental health awareness campaigns and programs should consider initiatives that would support

and encourage safety and crisis plans within the communities that may potentially deter harm and tragic events. And more importantly, the mental health campaigns should determine ways to introduce these practices without increasing stigmatization and the overgeneralization of mental illness and violence. Secondly, the mental health awareness campaigns and programs could provide resources for caregivers, schools, and communities to spotlight the available mental health services. Finally, the mental health awareness campaigns and programs should consider protest strategies that will address the negative attention in mass media given to people with mental illnesses. The protest strategies should engage interventions that reward media outlets that frequently broadcast positive images of people with mental illnesses in recovery and positive responses to mental health treatments that encourage people to access and utilize services.<sup>477</sup> These considerations of the mental health awareness campaigns and programs will assist with the social obligations related to people with serious mental illnesses and violence and to ensure access and utilization to mental health services.

### **Affordable Care Act and Justice**

In the consideration of social obligations in regards to access and utilization of health care, the United States has primarily only guaranteed Americans access to emergency services.<sup>478</sup> The original philosophy of the United States diverged from the other technologically advanced democracies in the world, such as Great Britain, Canada, Germany, New Zealand, and the Netherlands.<sup>479 480</sup> In these other democracies, there is much broader coverage of health care that affords the people with rights to more comprehensive, medically necessary services, which typically comprise of preventive care, curative care, rehabilitative and therapeutic services, and long-term care for mental diseases, disorders, and disabilities.<sup>481</sup> In claiming the social

obligations to health care, the countries are extending the moral sense of responsibility to a positive right to health care and requires “others to do something beneficial or enabling to right-bearers.”<sup>482</sup> In consideration of justice and health care as a positive right the following are considered: society has an obligation to assist people with health care, society has to duty to allocate health care to people, and each person in the society is entitled to their fair share of health care.<sup>483</sup> Accordingly, the principle of justice must be applied to determine the equity in distribution since health care has limitations with resources and technological capacities.<sup>484 485</sup>

Since the United States has historically endorsed emergency care in the United States, people with physical and mental diseases and disorders without financial resources to cover health care have experienced further disparities, discriminations, and impoverishments from not accessing and utilizing medically necessary mental health services. Subsequently, the PPACA has been instrumental at introducing and enforcing the concept of comprehensive, medically necessary health care as a positive right in the United States. The PPACA is demonstrating that health care as right increases opportunities and reduces burdens on society specific to people that are vulnerable or unable to participate in society. Even though, the moral status of the United States does not naturally endorse a positive right to health care, there are principles that accept positive rights of Americans, such as the rights to liberty and property.<sup>486</sup> Daniels reported, “The central observation is that disease and disability restrict the range of opportunities that would otherwise be open to individuals.” With disease and disability, people without access to health care have shortened lives and have despaired participation in society, such as positive right to liberties and property.<sup>487</sup> Contrariwise, when health care is available to all, the disease and disability can be diminished and effectively promote normal function allowing people to participate in the other opportunities and rights of society.<sup>488</sup> Since health care does restore and

promote normal function for people with diseases and disorders, the United States can justify the expansion of health care for all Americans beyond emergent care to medically necessary services.<sup>489</sup>

This principle of justice and health care as right has significant implications to people with mental illnesses. The historical accounts of people with the mental illnesses with limitations and restrictions increased disparities and further burdened society with financial responsibilities for vulnerable persons and exposed the general public to dangers of having people with serious mental illnesses without the appropriate supports and services within the community. By extending comprehensive coverage and access of health care, which is inclusive of physical and mental health services to all, people with mental illnesses have improved function and participate in society.<sup>490</sup> Subsequently, the societal obligation to care for the people with mental illnesses as vulnerable persons reduces.

In the United States, the MHPAEA ensured that mental health services were covered by insurance and group health plans the same as physical health services. The final ruling on the MHPAEA addressed access and utilization issues for mental health and substance use disorders by restricting limitations based on medical necessity standards, utilization techniques, and prescription formulary designs that were more rigorous than the physical health and surgical limitations.<sup>491</sup> The MHPAEA was the structural change that resolved the inequality between physical and mental health services; however, there continued to be inequalities related to access and utilization of mental health services. Since comprehensive medically necessary services are not naturally a basic right in the United States, in 2014, there were 50 million Americans without insurance to cover basic health care needs.<sup>492</sup> Of the uninsured population, there were 12 million people with diagnosable mental health or substance disorders without insurance and were unable

to access medically necessary services.<sup>493</sup> Subsequently, the PPACA was an additional structural change to society that guaranteed that the uninsured Americans could have access to health care including physical and mental healthcare. The PPACA had the following three fundamental objectives: 1. provided substantial funding to expand the poverty level for Medicaid programs, 2. extended tax credits for people without employer-sponsored coverage and purchased insurance through the Health Insurance Market Places, and 3. required all insurance and health plans to cover preexisting conditions and not discriminate on gender or current health status.<sup>494</sup>

The PPACA was influential in establishing access to health care for millions of people, moreover, the PPACA provided additional protections specific to people with mental illnesses.<sup>495</sup> The PPACA continued to enforce the principles of the MHPAEA by extending parity to Medicare, Medicaid, and the Health Insurance Market Places; furthermore PPACA was more stringent by requiring mental health coverage, where MHPAEA only required that if mental health coverage was offered, the coverage must be equal to the physical health coverage.<sup>496</sup> The MHPAEA addressed the financial requirements for mental health services, such as medical necessity standards, utilization management techniques, and standards for admissions, similarly, the PPACA interjected provisions that reduced these restrictive practices in Medicare, Medicaid, and Health Insurance Market Places and established out-of-pocket maximums for health care coverage.<sup>497</sup> Furthermore, PPACA incorporated nondiscrimination policies for Medicare and Medicaid specific to mental illnesses and disorders.<sup>498</sup>

In addition to reducing restrictions and financial burdens of insurance and access to healthcare, the PPACA also requires that insurance, health plans, and government programs have sufficient choices of providers for both physical and mental health services.<sup>499</sup> For the government programs, there must be access to mental health providers without unreasonable

delay and admission and rate-setting requirements cannot restrict people with mental illnesses from receiving mental health services.<sup>500</sup> Additionally, the PPACA transitions the philosophy for the right of health care beyond emergent care to medically necessary services including preventive and therapeutic services.<sup>501</sup> For preventive care, the financial burdens for the people in the government programs have been reduced and no longer require co-pays, co-insurances, or deductibles.<sup>502</sup> Specifically to mental health services, the PPACA includes preventive that include behavioral health and depression screenings and services, alcohol and drug use screenings and counseling, and tobacco screening and cessation.<sup>503</sup>

With the MHPAEA and PPACA, there are significant transitions in the social obligations. The regulatory and structural changes are provoking medically necessary health care rights and discouraging institutional stigma and discrimination towards health statuses, specifically mental illnesses. With the improvements to the health care structure in the United States, there should be an increase in mental health services for the millions of people with mental illnesses that previously were not accessing and utilizing mental health services. As the structural changes to health care specific to mental health services as personal rights come to culmination, the underfunding of mental health was revealed. Consequently, there has become a social obligation to stimulate mental health services with additional funding so that the medically services will be available. In the 2016 budget bill H.R. 2029 passed on December 18, 2015, President Obama announced the additional funding for mental health services and initiatives, that included some of the following: “\$85.4 million boost for research at the National Institute of Mental Health (NIMH), \$50 million more for services at the Substance Abuse and Mental Health Services Administration (SAMHSA), and \$255 million increase for veterans mental health treatment.”<sup>504</sup>

With the changes in the structure and available mental health services, the mental health awareness campaigns and programs can integrate the new individual rights to health care and the additional programs available to people with mental illnesses. By providing education and support to the new access and funding, people with mental illnesses will have increased availability to mental health services that will reduce psychiatric symptoms and psychological distresses, restore functioning to acceptable recoveries, and promote recovery and well-being within the community.

## **Conclusion**

Compounding this information into the education, contact, protest, and mass media strategies of the mental health awareness campaigns and programs will reduce discrimination and stigma and promote access and utilization of mental health services. Ultimately, mental health campaigns that effectively address current topics in mental health, advancements in funding or treatment practices, and social obligations of the general public including principles of sympathy and morality will assist in the reduction of institutional, public, and personal stigma and encourage the increase of access and utilization for mental health services that are medically necessary. Interestingly, expanding the coverage of mental health services to comparable levels of physical health services has brought the promotion of mental health preventive care and the attention to the overall well-being of people with mental illnesses as realized objectives and practices in contemporary mental health services.<sup>505</sup>

## **Chapter 7 – Conclusion**

The purpose of this doctorate project is to outline the moral importance of mental health awareness campaigns and programs to encourage people with mental illnesses to access and utilize mental health services since contemporary practices are demonstrating recovery from mental illnesses. However, there are significant vulnerabilities and barriers for people with mental illnesses when attempting to access and utilize mental health services. Primarily, the vulnerabilities and barriers to mental health services are derived from the stigma of mental illnesses and the fears of mental health services. The stigmatization has resulted in the stereotypes and discrimination that has produced individual, public, and institutional barriers to people accessing and utilizing mental health services. Subsequently, advocacy groups and professional organizations have attempted various change strategies to replace the fallacies of mental illnesses for persons, groups, and general populations so that the societal response to people with mental illness and mental health services will engage common morality and cultivate social obligations to promote and protect these vulnerable persons in the community.

### **Summary of the Project**

The beginning of the doctoral project presented the historical accounts of madness and mental illnesses that have been prevalent throughout history and widespread throughout societies. Additionally, the societal responses to madness and mental illnesses were classified by comparing the intellect from the previous era, the societal and institutional perceptions of madness and mental illness, and the science including terminology and treatment.<sup>506</sup> The review of the four chronological eras of the Pneumatic Age, the Age of Optimism, the Militant

Age, and the Psychoboom was important for understanding the current practices and standards in mental health services and the evolution of stigma towards mental illnesses and fears of treatments.<sup>507</sup> The historic misconceptions and lack of understanding of madness has resonated into our language, media, and understanding and embedded stigma towards people with mental illness into our current societies. Moreover, the shocking and abusive mental health practices from preceding generations perpetuates negative discernment into contemporary mental health treatments and practices, and people with mental illnesses have become disinclined to access mental health services.<sup>508</sup> To the contrary, mental health services have emerged into treatments and practices that have evidenced-based practices, ethical and professional standards, and recovery-based services that promote normal functioning for people with mental illnesses. Even as the mental health services are advancing, millions of people with mental illnesses are not accessing and utilizing treatments; therefore, common morality has obliged advocacy groups, government agencies, and the general public to promote medically necessary services to reduce burdens of mental illnesses to the society and vulnerable persons.

Throughout history, society has stereotyped people with mental illnesses as insane, peculiar, deviant, infantile, and limited mental capacity. People with mental illnesses disrupted society and inconvenienced the families and caregivers, therefore, people with mental illnesses were isolated from the community with limited rights and liberties. The separation and confinement further alienated people with mental illnesses from the general populations and increased the mystery and misconceptions of madness and mental illnesses. Additionally, the horrific accounts of psychiatric practices that included bloodletting, lobotomies, and perceived euthanasia also permutated within society scrutinizing the legitimacy of psychiatry and mental health services. Chapter 3 revealed the stigmatization towards people with mental illnesses and

mental health services and disclosed the inequalities and discriminations that subjected people with mental illnesses to additional disparities and lost opportunities in life.

The numbers of people with mental illnesses is alarming since the evidence-based practices are producing outcomes of recovery allowing people with mental illnesses to function within the community. Subsequently, there is a need to stimulate change in the societal perceptions towards people with mental illnesses, so people with mental illnesses will be empowered to access and utilize medically necessary services. The purpose of Chapter 4 was to examine the strategies that may change the stigma towards people with mental illnesses and the fears of mental health services. There are different levels of stigma and prejudices towards people with mental illnesses; however, the following three methods of change, education, contact, and protest, have had affirmative results in redefining attitudes and prejudices towards people with mental illnesses.

The purpose of Chapter 5 was to validate the efforts of advocacy groups and professional organizations to appeal to society with anti-stigma campaigns and mental health awareness programs that have publicized the vulnerabilities and discriminations for people with mental illnesses. The anti-campaigns were constructed from the various methods of change that included trainings, education and contact strategies, and multi-faceted programs and have shifted attitudes and responses towards mental illnesses. Accordingly, if the anti-stigma campaigns compounded information that advocated for mental health services and encouraged access and utilization, people with mental illnesses would be more likely to obtain the needed mental health services. Since there are so many people lacking needed mental health services and people with mental illnesses are vulnerable to lost opportunities from structural, public and individual stigma,

there are social obligations to reduce stigma and promote the access and utilization of mental health services.

Furthermore, the responses to stigma and lack of utilization has been assenting into institutional and structural changes that compel society to support access to health care and mental health services. The purpose of Chapter 6 was to examine recent societal responses to people with mental illnesses, such as community mental health models, prevention of harm and tragic events, and the legislation to expand access and utilization of health care. As a result there are responsibilities of society to continually weigh and balance the protections and common goods for the community versus the rights and liberties of people with mental illnesses. Therefore, the mental health awareness campaigns and programs must address the benefits of providing people with mental illnesses appropriate knowledge and access to mental health services. By providing comprehensive education and supports to availability, funding, and outcomes, the research suggested that people with mental illnesses could have increased access and utilization to mental health services that will reduce psychiatric symptoms and psychological distresses, restore functioning to acceptable levels of recovery, and promote overall well-being within the community.

### **Key Findings**

There are five key findings identified from the research that establishes the ethical justice of comprehensive mental health awareness campaigns and awareness programs so that people with mental illness will access and utilize mental health services. First, contemporary mental health services have implemented ethical and professional standards while reducing psychiatric disorders and psychological distresses. Historically, physicians and health care providers have

struggled with treating mental illnesses, because there was excessive emphasis to discover cures and the exact pathology causing the mental illnesses with minimal rights and protections for the people with mental illnesses.<sup>509</sup> However, mental health treatments, including neurology, psychiatry, and psychotherapy, are transcending to reduce disabilities, restore basic functioning, and increase quality of life for people with mental illnesses along with relying continuing to rely on the innovations of sciences.<sup>510</sup> Contemporary mental health services still conducts clinical trials and tests evidence-based practices to assist with recovery, but the patients are protected by the professional standards that oblige practitioners to minimum ethical and safety standards.<sup>511</sup> As a result, people with mental illnesses are less vulnerable to abuses,<sup>512</sup> and evidence-based practices are producing positive outcomes, including improvements in health and life expectancy, from accurate diagnosing and effective treatments.<sup>513</sup>

Second, millions of people with mental illnesses are not accessing and utilizing medically necessary services. According to the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMSHA) Center for Behavioral Health Statistics and Quality, in 2012, 42 million adults in the United States reported some type of mental illness within the 12-month period.<sup>514</sup> However, only 32 million of those adults received mental health services or treatments.<sup>515</sup> Moreover, the Epidemiologic Catchment Area (ECA) Study reported that less than 30% people with mental illnesses symptoms seek mental health service and approximately 40% of people diagnosed with severe mental illnesses, such as schizophrenia, are not actively in treatment.<sup>516</sup> The underutilization of mental health services is astonishing and raises questions of social responsibility for the general public, professional organizations, advocacy groups, and Federal and State governments.

Third, stigma towards people with mental illnesses and fears of mental health services have reduced access and utilization of mental health services. There are several barriers that cause people with mental health illnesses to delay or not access mental health services; however stigma towards mental illnesses that results in stereotypes continues to be the reason for the reduction in utilization for mental health services.<sup>517</sup> The stigma towards people with mental illnesses continues to reduce opportunities in life, therefore, people do not want to be diagnosed or labeled with mental illnesses.

Fourth, anti-stigma programs are changing attitudes and have positive relationships with increasing access and utilization of mental health services. Even though, stigma still exists, the anti-stigma campaigns are changing attitudes, affect, and behavior, but additional research is needed to prove that stigma is being reduced and access and utilization is being increased.<sup>518</sup> The anti-stigma campaigns are relying predominantly on the three social marketing strategies of public education, direct contact with consumers and providers of mental health services, and protest for negative portrayals or responses to people with mental illnesses.<sup>519</sup> Again, these strategies are consistent with previous research for stimulating change; however, adding rewards and promotions encourages positive responses from the general public for participating with the initiatives has provided additional changes in attitudes, affect, and behavior towards people with mental illnesses.

Fifth, compounding anti-stigma campaigns and mental health awareness campaigns and programs with current issues and advancements in mental health services can reduce stigma and increase access and utilization of mental health services. With large mental health awareness campaigns and programs, redefining mental illnesses while reducing stigma has been the focus, but compounding information and contact with mental health providers can help reduce fears of

treatments and increase access and utilization of mental health services. Moreover, by including information about institutional changes, such as, community-based and patient-centered treatments and increased availability of insurance and providers, may further improve access and utilization of mental health services. Also, the expansion of mental health awareness campaigns and programs have incited responses of social obligations for people with mental illnesses to reduce disparities and ensure access and utilization of mental health services.

### **Future Considerations**

In addition to the key findings, this doctorate project has revealed future considerations that will further engage people with mental health services and promote recovery. The Patient Protections and Affordable Care Act (ACA) and Federal resources continue to transcend health care as an individual right and the availability of preventive care for mental health services become realized, mental health services will transition to the mental health promotion. The shift in ideology will encourage all people to participate in mental health services and results in early interventions to people who are experiencing psychiatric disorders and psychological distresses. In 2004, the World Health Organization (WHO) implemented concepts that will boost the consideration of mental health well-being which included: “there is no health without mental health, mental health is more than the absence of mental illnesses, mental health is determined by socioeconomic and environmental factors, mental health is linked to behavior, and mental health can be enhanced by effective public health.”<sup>520</sup> Mental health promotion encompasses prevention, treatment, and maintenance, which is different than the historical approaches to only treating the symptoms of mental illnesses.<sup>521</sup>

With the expansions of prevention and maintenance mental health services in the PPACA and additional funding added to the budgets of the United States, there is new philosophy to incorporate mental illness into primary care and ensure access and effectiveness through public health.<sup>522</sup> When mental health is considered as public health there is a focus on prevention from a population perspective and addresses the environmental and contextual influences on health.<sup>523</sup> Prevention mental health will include screenings and early treatment of conditions even for people that may not have officially diagnosed with mental illnesses.<sup>524</sup> Future considerations related to public health and preventative care are needed to determine if this will reduce stigma and increase earlier access and utilization of treatment. Moreover, by including this type of information in the mental health awareness campaigns and programs, there may be positive societal responses that stimulate the reduction is stigma towards mental illnesses and increase access and utilization of mental health services.

## **Conclusion**

The United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (SAMHSA), endorses that the mental health awareness campaigns and programs have been successful at changing attitudes and societal responses related to the stigma towards mental illness and provides recommendations to include education, protest, and mass media to change public opinion and prompt social obligations. Consequently, if anti-stigma campaigns and programs integrated the progress of mental health treatments and ethical and professional standards while disseminating information on the structural changes in health care; people with mental illnesses would be more likely to access and utilize medically necessary mental health services.

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