



## Module 7: Mental Health

### Part 1: History and Definitions

Hi, my name is Jonathan Singer. I'm on faculty at the School of Social Work at Temple University, and I'm very excited to be here today to talk with you about Mental Health Past, Present, and Future: Children and Adolescents.

The goal for Healthy People 2020 for children and adolescents is to improve mental health through prevention and by ensuring access to appropriate quality mental health services. The Healthy People 2020 objectives are to increase the proportion of children with mental health problems who receive treatment and increase the proportion of primary care physician office visits where youth age 12 to 18 years are screened for depression.

The learning objectives for today's module are to understand the current state of mental health services for children and youth, to review the best practices for providing services to children and youth, and to identify strategies to increase services for children and youth.

Part I: Historical Context and Definitions of Mental Health and Illness.

This figure shows the trajectory of the historical context for mental health services, and I'm going to briefly review how folks were thinking about mental health, mental illness in Colonial America, then on to 19th Century America, and then the War Years, 1914 to 1945, and then in the Modern Era.

Colonial America: if we look at this picture and we see that everybody is outdoors, and that's an important piece about the conception of mental illness, mental health, and how it's treated. The colonies adopted the Elizabethan Poor Laws. The idea was that society had a responsibility to take care of the poor.

Mental illness and economic dependency were so closely related that codes and laws primarily intended for the poor also included references to the mentally ill. They talked about care of distracted persons and idiots in the community, and this care was called outdoor relief. The idea was that the community took care of these folks in the community in which they lived. Treatments for people with mental illness, who were also poor, included prayer and bloodletting.

As we move to the 19th Century in America, we see in this image that it looks very different from colonial America. For one thing, we're in a building, and for the second thing, there are professionals surrounding people who are clearly suffering some sort of emotional behavioral problems.

The 19th Century is characterized by the enlightenment era. Mental illness is understood to be environmental and therefore treated, and treatments were understood to demonstrate effectiveness. The person who was depicted in that last picture or painting was Louis Pennell, and he was a French physician who said, "You know what, the treatments that we used in the previous centuries were not effective because they didn't demonstrate any improvement in the person's symptoms. We are in the Enlightenment Era. We now have to demonstrate outcomes."

And furthermore, because there was a redistribution of the population from rural areas into the cities there was urbanization, there was immigration, and this mobility really challenged outdoor relief. It was very difficult to take care of people in your community if your community wasn't a couple hundred people.

So this became the rise of indoor relief, poor houses, orphanages, and insane asylums, which these days the term insane asylum is very pejorative. But in those days it was considered state of the art. Efforts to have mental health treatment codified at the Federal



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level failed. And what this means is that reformers, such as Dorothea Dix, tried to get the Federal Government to say, you know what, we have a responsibility to care for the poor. But the laissez-faire policies of the time said no, that's not a Federal thing. And that set precedent all the way through FDR's New Deal.

The War Years: So here we have an image of a woman carrying a child into what appears to be a wartime nursery. The war years were really crucial in understanding how we get to our modern understanding of mental illness. In 1910 there were about 100 child guidance centers that were established that were aimed at prevention and early intervention and treatment for childhood problems. Later on you had psychologists, such as Alfred Adler who recognized that through World War I there was incredible inhumanity, man to man, as they said back then, person to person. And the idea was that if we can address these issues in childhood people won't be so cruel to each other.

In the 1930's we first see the first International Congress on Mental Hygiene in Washington, D.C. bringing together more than 3,000 individuals from 41 countries. And this led directly into the 1930s where we have the New Deal federalizing public assistance, something that Dorothea Dix had failed to convince the Federal Government of 70 years earlier.

As we move through to World War II we see soldiers returning from war with significant mental illness, and the public through World War I and World War II becomes familiar with psychiatric disorders that they are calling shell shock.

All of this leads us into the Modern Era. Here we have John F. Kennedy signing the Community Mental Health Act. And right after World War II we have the creation of the National Mental Health Act and that created in 1949 the National Institute of Mental Health. And we see in 1952 the publication of the first Diagnostic and Statistical Manual, which we'll talk a little bit more about in a minute.

In 1963 we have the Mental Retardation Facilities and Community Health Centers Construction Act, also known as the Community Mental Health Act. And this is important; because what had happened was that you had all of these folks who were experiencing severe psychiatric illness placed in institutions.

But after years of neglect and failed treatment, it became very clear to advocates and policy folks that institutionalizing a large segment of America was not helping. And so Lyndon Johnson, John F. Kennedy, they all came together to de-institutionalize the United States. And what were they going to do with folks who were no longer in institutions? They were going to put them out in the community mental health centers, which is what that 1963 act was supposed to do.

By 1979 the National Alliance on Mental Illness, now called the National Alliance on the Mentally Ill, was founded in part because communities had not actually gotten it together to create community-based treatment for folks who had been de-institutionalized. And there was significant stigma and shame surrounding mental illness that was in fact detrimental to those who previously had been institutionalized and now were in communities.

In 1996 we see the passage of the first Mental Health Parity Act, and this was a landmark piece of legislation, because what it said was, insurance companies had to fund mental illness, treatment for emotional behavioral problems the same as medical problems. Now there weren't very many teeth in this piece of legislation, and so in 2014 we have the Mental Health Parity Equity Act, which went into effect in July 1, 2014, which said that dollar for dollar if you're going to pay for 25 weeks of this treatment for this medical problem, you have to consider 25 weeks for this treatment of an emotional or behavioral problem.

So where are we now? Well, the current Mental Health System is a fragmented patchwork of both indoor and outdoor relief; indoor relief in the sense that we have institutions, we have residential treatment centers, we have long-term nursing homes, we have in-patient stays, psychiatric in-patient stays, and we have outdoor relief. We have folks being treated in their communities by local community groups as well as outpatient community mental health.

Now the passage of the Affordable Care Act established a formal integration of mental and physical healthcare. And that of course was what in part resulted in the Mental Health Parity Equity Act being passed last year.



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**Definitions:** So what is mental health and how do we define mental illness and disorders? The World Health Organization defines mental health as, "A state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Now the flip side of mental health is mental illness. The Surgeon General's Report in 1999 defined mental illness as, "Health conditions that are characterized by alterations in thinking, mood, or behavior, or some combination thereof, associated with distress and/or impaired functioning."

If you're familiar with the Diagnostic and Statistical and Mental Disorders, you will recognize that this definition uses the same concepts that we use in our current definitions of psychiatric illness: symptoms, distress, and/or functional impairment. These are the foundations of our current System of Psychiatric Diagnosis. So the definition of mental illness in the Surgeon General's report is consistent with how we define things in the Diagnostic and Statistical Manual.

**So the DSM:** This is a brief history of the DSM because its impact has been so significant on mental health, mental illness, and our understanding of psychopathology in children. What we have in this image is we have all of the DSMs from one to five, starting in 1952 all the way to 2013.

**The DSM-I and -II:** The precursor is that in 1900 the first International Classification of Diseases book came out. And if you remember, back in the 19th Century we had the enlightenment, the idea that things could be cured. Well this was a pretty radical idea in an era where people who got sick tended to die. And so for the first time you have this idea that sometimes you have illnesses that can be treated, and people can survive.

So about 50 years after the first ICD, the ICD-6 was published, and included six mental illnesses. A few years later the Diagnostic and Statistical Manual First Edition came out and it defined mental illness as a reaction. Now why was it a reaction? It's because people were seeing people reacting to the effects of war. They understood mental illness as a reaction, a biological reaction to the traumas of shell shock, those sorts of things.

By 1968 mental illness was understood primarily in Freudian terms, as either neuroses or psychoses. Then we jump ahead to 1980 and there's a radical revision of our understanding of mental illnesses. Mental illness is no longer considered theoretical, as in Freudian, as in you can identify the reason why somebody has a mental illness.

In DSM-III, it's atheoretical; people are looking primarily at criteria for disorders rather than reasons. The DSM-III introduces what they call the multi-axial system, five axes; a primary diagnosis, diagnoses that might be due to medical conditions. You have the psycho-social and environmental stressors. And then you have a general sense of functioning.

Now the first DSM and the second DSM were not based on research. The third DSM, however, was—well, not entirely. To the extent that they could, it relied on research to figure out which diagnoses could be most reliably provided by two psychiatrists who were seeing the same patient. Symptoms however were determined by committee vote, and many disorders ended up having poor inter-rater reliability.

So DSM-III-R, the revised version, had substantial revisions based on data that had come in in the seven years after the third DSM was published.

**Now DSM-IV:** 1994, this was a big year for the Diagnostic and Statistical Manual. The criteria were determined by empirical data, almost exclusively rather than committee vote. There were 12 field trials conducted to establish the inter-rater reliability and validity of different sets of criteria, which in some cases established new diagnoses. It eliminated the distinction between organically based and psychologically based disorders.



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Now the DSM-IV-TR, which stands for text revisions, wasn't a very substantial revision. In fact there were almost no diagnostic changes in it, and many people criticized it for simply being an opportunity for the American Psychiatric Association Press to make some money.

The DSM-V: Remember, DSM-IV was published in 1994, no substantial revision in 2000, and here we are almost 20 years after the last major revision, we have DSM-V. Notably most of the disorders are the same as in DSM-IV. There are some changes. They removed Asperger syndrome. They removed the bereavement exclusion for depression, which means that you can be diagnosed with depression even if you were in a period of bereavement after the loss of a loved one. They added new criterion for post-traumatic stress disorder. They eliminated the multi-axial system, meaning that you no longer provide diagnoses based on five axes; you only do it on one.

And now it's organized by life course, which means that if there are diagnoses occur in childhood that are different diagnoses than occur later on in life, but those diagnoses are somehow related to each other, they are now considered the same category, rather than dividing up diagnoses simply by when in the life they occur, such as childhood, older adulthood.

Now the head of the DSM-IV Task Force, Allen Francis, was highly critical of the changes in DSM-V, and waged a very public campaign. But a recent survey found that approximately 80% of mental health providers who use the DSM-V were positive about the changes. And these changes will go into effect in 2015.