fields receive funding from a variety of disconnected sources, with little coordination. Regier et al. (1993) describe it as a de facto mental health service system because it is simply a loosely coordinated set of public (government funded or operated) and private services. The US Surgeon General (1999) refers to four segments within the de facto system: (1) specialty mental health services, (2) general medical/primary care services, (3) human services, and (4) voluntary support network services.

Specialty mental health services are those provided by mental health specialists, including social workers, psychologists, psychiatrists, and counselors. Services are provided in private for-profit, private not-for-profit, and public settings.

General/medical primary care service providers include doctors and nurses in hospitals and primary care physicians in clinics. For many people who enter the de facto mental health system, the first point of contact is through medical doctors or hospitals. Primary care physicians have been the focus of educational efforts by mental health professionals to assist them in recognizing early symptoms of mental disorders, particularly clinical depression.

The human service sector consists of social services, school-based services, counseling, vocational rehabilitation, prison-based services, and religious-based social services. This sector is by far the largest provider of children's mental health services.

The voluntary support network sector consists of self-help groups such as Alcoholics Anonymous (AA) and similar 12-step programs; Recovery Inc., a support group for people with mental disorders; and other support groups sponsored by voluntary organizations like the National Alliance on Mental Illness and Mental Health America. The number of self-help groups has been increasing as consumers and their families recognize that social support can buffer the effects of stress. Many consumers perceive the value of activities that promote wellness and view self-help and support groups as powerful adjuncts to professional services.

Managed Care As a result of the managed care movement (discussed in Chapter 9), health insurance plans often give oversight of mental health services to companies with expertise in behavioral health. The goal is to reduce costs by emphasizing cheaper, brief treatments or group treatment approaches, by making sure applicants for service meet criteria, and by reviewing the medical necessity of all treatment. Incentives, in which professionals receive bonuses for providing less care, and risk-sharing contracts, in which providers agree to treat a specified number of consumers for a specified cost, are features of managed behavioral health care service delivery. Limiting the number of annual outpatient visits and limits on inpatient care are also common features of the managed care system. Although there is a great deal of controversy surrounding managed care, it is unlikely to vanish as health care costs continue to rise. Social workers are advocating for all Americans to be able to afford and access mental health coverage. As will be discussed later, there has been hope that continued implementation of the Affordable Care Act would assist in this effort. As of the time this book was written, it is unclear whether the Affordable Care Act will be repealed and what might take its place.

EP 3b

Deinstitutionalization Deinstitutionalization was prompted by the need to reduce the costs of psychiatric care, by attention to the rights of people who were involuntarily hospitalized, and by advances in evidence-based psychosocial and psychotropic drug treatment. With treatment, people are able to function in ways that were previously impossible. Between 1970 and the 1990s, the inpatient population of state and county institutions fell from 413,000 beds to below 100,000 (Grob, 2001). Despite increases in the overall population, inpatient beds have continued to decline, and currently the United States has a deficit of more than 123,000 inpatient beds. This has meant that people with severe mental illness have long waits in emergency rooms, jails, and hospitals to wait for an open bed (Ollove, 2016).

Deinstitutionalization was implemented with little understanding of its individual and social consequences (Mechanic, 1999). The Community Mental Health Center Act was never fully funded, and insufficient housing, treatment, rehabilitation, and education services were provided for people with serious mental disorders. Deinstitutionalization is blamed for the homelessness of a large number of seriously mentally ill people and for the inability of mentally ill people and their families to secure treatment. As a result of the deinstitutionalization movement, many mental hospitals were permanently closed, leaving fewer options available for people who had difficulty benefiting from treatment offered in the community.

Criminalization The fragmented delivery system is further complicated by the criminalization of mental health problems coupled with ineffective follow-up care after discharge from hospitals and inpatient psychiatric facilities. A report found that about 356,268 people with severe mental illness were in jail or prison and only about 35,000 of those with severe mental illness were in state psychiatric facilities. Depending on the state and facility, as high as 60 percent of prison and jail inmates have a serious mental illness (Lithwick, 2016). On any given day, the country's three largest jail systems, in Chicago, Los Angeles, and New York, have more than 11,000 people receiving treatment for mental illness (Fields & Phillips, 2013). A Treatment Advocacy Center report summarized the problem, noting, "Prisons and jails have become America's new asylums" (Torrey et al., 2014). When individuals with mental disorders live in the community and do not receive treatment, their abnormal behavior sometimes results in arrests rather than in referral for treatment. However, the common belief that people with mental illnesses are more violent than average is not borne out by research (American Psychological Association [APA], 2014). The vast majority of violent crime is committed by people without mental illness, and the vast majority of people with mental illness are not violent.

LO 4 Community Treatment Historically, inpatient clients have not always connected with case management services after discharge (Belcher & DeForge, 2005). Part of the problem is poor coordination between inpatient hospital settings and community mental health clinics. Also, consumers who have not proved to be a danger to themselves or others are not required to accept treatment. Some consumers choose not to accept treatment because they fear or have