Chapter 24 Populations Affected by Mental Illness

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Objectives

Upon completion of this chapter, the reader will be able to do the following:

1. Explain the concepts of community mental health, and discuss the importance of community mental health promotion in special populations.
2. Discuss the historical context for contemporary community mental health care.
3. Describe biological, social, and political factors associated with mental illness.
4. Illustrate the impact of natural and human-made disasters on the mental health of communities.
5. Describe some of the most common types of mental illnesses encountered in community settings.
6. Discuss the problem of suicide and recognize suicide warning signs.
7. Describe different types of evidence-based treatment for mental disorders, including use of psychotropic medication management, community case management, and crisis intervention.
8. Describe the role of mental health nurses in the community.

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Key Terms

2008 Mental Health Parity and Addiction Equity Act

Affordable Care Act

agoraphobia

anorexia nervosa

anxiety disorders

anosignosia

attention deficit disorder

attention deficit/hyperactivity disorder

bipolar disorder

bulimia nervosa

case management

Community Mental Health Centers Act

co-occurring

comorbidity

Crisis Intervention Team

deinstitutionalization

depression

generalized anxiety disorder

major depression

mental health

mental health consumer

mental illness

panic disorder

phobia

post-traumatic stress disorder

psychotropic/psychotherapeutic medications

schizophrenia

severe emotional disorder

severe mental illness

stigma

Mental health refers to the absence of mental disorders and to the ability to function socially and occupationally. **Mental illness** consists of diagnosable mental disorders that affect alterations in thinking, mood, or behavior associated with distress and impaired functioning. Other effects of mental illnesses including disruptions of daily function and lifestyle, such as incapacitating personal, social, and occupational impairment as well as premature death. Mental health can be affected by numerous factors, such as biological and genetic vulnerabilities, acute or chronic physical dysfunction, environmental conditions, and stressors. Twenty-first century community mental health necessitates comprehensive mental health services, inpatient, outpatient, home-based, school, and community-based programs for individuals, families, and populations at need. Threats such as vulnerability, poverty, homelessness, cost and limited accessibility to community mental health care can be pervasive. Whether populations in need live in rural or urban settings, people need mental health services. Community mental health care can exist throughout all levels of prevention and can be designed to supplement and decrease the need for more costly inpatient mental health care delivered in hospitals. A community's mental health is a reflection of community as a whole. Community mental health professionals work with populations at risk such as homeless veterans, families, children and the elderly.

It is estimated that up to 25% of all U.S. adults have a mental illness and that nearly 50% of U.S. adults will experience at least one mental illness during their lifetimes (Reeves et al, 2011). Mental illness is a significant public health problem affecting not only the person with mental illness but their family, friends, schoolmates, work mates, and others. Mental illness is associated with lower use of health care, reduced adherence to treatment therapies for chronic diseases, and higher risks of adverse

Rates for intentional and unintentional injuries are two to six times higher among people with a mental illness than in the general population. The knowledge that many mental illnesses can be managed successfully offers hope, and increasing access to and use of mental health treatment services could substantially reduce the associated morbidity. There are evidence-based practice (EBP) models consisting of community-based programs of intervention, education, and collaboration. Continual monitoring of mental illness is critical in providing appropriate organizations the data they require to assess the need for mental and behavioral health services and to inform the provision of those services.

The **Affordable Care Act** (ACA) builds on the **2008 Mental Health Parity and Addiction Equity Act** to extend federal parity protections to 62 million Americans (HealthCare.gov, 2013). This parity law aims to ensure that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for medical and surgical care. The ACA builds on the parity law by requiring coverage of mental health and substance use disorder benefits for millions of Americans who currently lack these benefits.

More than ever, community mental health nurses and interdisciplinary community teams face multiple challenges such as complex patient **comorbidity**, lack of resources, competent mental health professional workforce and law enforcement, physical facility inadequacies, and the stigma of mental illness. The purpose of this chapter is to describe critical issues that affect the mental health of individuals, families, groups, and special populations and to explore the potential influences and advocacy issues that nurses can be involved with. The chapter depicts issues that affect individuals, families, groups, and populations and explores promising EBP programs and educational models utilized in community mental health.

Severe mental illness (SMI) is a diagnosis applied to any adult who currently or at any time during the past year has had a diagnosable mental, behavioral, or emotional disorder with moderate, severe, or extreme functional behavior in specific lifestyle areas. These mental health disorders of persons 18 years of age or older present emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. SMI mental disability is severe and persistent, resulting in a long-term limitation of functional capacities for primary activities of daily living, such as interpersonal relationships, homemaking, self-care, employment, and recreation. There are hopeful models of care that integrate team approaches with patients with SMI and families (LeVine, 2012).

Overview and History of Community Mental Health: 1960 to the Present Day

The National Institute of Mental Health (NIMH) initially developed a Community Mental Health Center (CMHC) program in the 1960s. CMHCs were designed to provide comprehensive services for people with mental illness, locate these services closer to home, and provide an umbrella of integrated services for catchment areas of 125,000 to 250,000 people. These centers were intended to provide prevention, early treatment, and continuity of care in communities, promoting social integration of people with mental health needs. In 1963 President John F. Kennedy signed the **Community Mental Health Centers Act** (CMHCA) which resulted in deinstitutionalization and the closing of mental institutions. As a result, patients were released into communities too often without supporting community services. Further cuts in housing and other services throughout the 1980s resulted in a new population of homeless individuals in the United States.

Table 24-1 provides a snapshot of the development of community mental health from the 1960s to present day.

TABLE 24-1 Community Mental Health Movement from the 1960 to the Present Day

1960	Blue Ribbon Panel report *Action for Mental Health*	Recommendations for intensive care of acutely ill mental patients and community mental health clinics
1963	Community Mental Health Clinics Legislation	Community mental health centers in some urban communities
1960s	Deinstitutionalization	Discharged mentally ill from state hospitals, patients returned to communities with inadequate resources (i.e., finances, housing, health care, supportive employment)
1981	Mental Health Block Grant, as part of the Omnibus Reconciliation Act	States develop comprehensive mental health plans for persons with serious mental illness
1986	State Mental Health Planning Act	
1999	U.S. Surgeon General's Report on Mental Health	Acknowledging mental illness as a disease
2008	Mental Health Parity and Addiction Equity Act of 2008	Insurance coverage for mental health and substance use conditions
2010	Affordable Care Act	Builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal parity protections to 62 million Americans

Deinstitutionalization Cause and Effects

Deinstitutionalization is the release of institutionalized people, especially mental health patients, from an institution for placement and care in the community. From 1955 to 1980, the number of mentally ill patients in state facilities fell from 559,000 to 154,000 as patients were moved back into their communities. Even though national deinstitutionalization was initiated in 1965 through the community mental health centers program, there had been significant movement of dislocated patients from state institutions for some 10 years prior. This national movement was also concerned with civil rights issues and the conditions of the state institutions. These questions and concerns led courts throughout the country to limit involuntary institutionalization and to set minimum standards for care in institutions. At this time there were not sufficient community resources, such as adequate housing, supported employment, community mental health professional workforce, and other community mental health care services, available throughout the country to meet the needs of patients coming back to communities. There was a beginning evolution in the structure, practice, experiences, and purposes of community mental health care in the United States. The Community Mental Health Centers Act of 1964 provided federal support for mental health services. The Act supported measures to implement facilities to care for those who were mentally retarded and to construct community mental health centers.

improvements in the social welfare system, and provision of community support for this population, and shortly thereafter, the federal government recommended linking community mental health services with informal community support services to improve treatment options.

Present-Day Community Mental Health Reform

Mental health reform works toward monitoring federal legislation, administration activity, and public education initiatives. Such reform policies make community mental health a national priority and establish early access, recovery, and quality in mental health services as quality standards in our nation's mental health care delivery systems. For example, the epidemic of gun violence and school safety is being addressed on a federal level with Project AWARE from the U.S. Department of Health and Human Services' (USDHHS's) agency from Behavioral Health Workforce (HHS Project AWARE). For military veterans and their families, the U.S. Department of Veterans Affairs (VA) is attempting to bring attention to education and community resources through the National Center for PTSD (Post-Traumatic Stress Disorder). The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization, dedicated to educate and advocate for access to services, treatment, support services, and research. President Barack Obama has initiated BRAIN (Brain Research through Advancing Innovative Neurotechnologies), new research effort to revolutionize our understanding of the human mind.

Medicalization of Mental Illness

The American Psychiatric Association (APA) work *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM V, 2013; APA, 2013) has supported the medicalization of mental illness and has helped put mental disorders on parity with other diseases. With mental health parity, schizophrenia and depression may be treated as forcefully with treatment as diabetes. There is hope that federal laws barring health insurers from imposing lower coverage limits on mental health services than they do on other medical treatments will change. Medicalization of mental health looks at holism, health, and understanding of illness on a functioning level and is seen as treatment toward the absence of disease (Smith, 2012, Vilhelmsson and Svensson, 2011).

Brain Neuroimaging, Genetics, and Hope for New Treatments

Brain imaging scans, also called neuroimaging scans, are being used more and more to help detect and diagnose a number of medical disorders and illnesses. Currently, the main use of brain scans for mental disorders is in research studies to learn more about the disorders.

Researchers use neuroimaging to study healthy brain development and the effects of mental illnesses or the effects of mental health treatments on the brain. Brain scans alone, however, cannot be used to diagnose a mental disorder, such as autism, anxiety, depression, schizophrenia, or bipolar disorder (NIMH, 2010).

HEALTHY PEOPLE 2020: Mental Health and Mental Disorders

Healthy People 2020 is a collaboration among federal, state, and territorial governments and private, public, and nonprofit organizations to set national disease prevention and health promotion objectives (USDHHS, 2013). The *Healthy People 2020* box lists several objectives that cover issues

HEALTHY PEOPLE 2020: Objectives Related to Mental Illness and Health

Mental Health Status Improvement

MHMD–1: Suicide

MHMD–2: Adolescent suicide attempts

MNMD–3: Eating disorders

MHMD–4: Major depressive episodes

Treatment Expansion

MHMD–5: Mental health treatment provided in primary care facilities

MHMD–6: Treatment for children with mental health problems

MHMD–7: Juvenile justice facility screening

MHMD–8: Employment of persons with serious mental illness

MHMD–9: Treatment of adults with mental health disorders

MHMD–10: Treatment for co-occurring substance abuse and mental disorders

MHMD–11: Depression screening by primary care providers

MHMD–12: Receipt of mental health services among homeless adults

From HealthyPeople.gov: *Healthy People 2020: Topics & objectives: Mental health and mental disorders, 2013*. Retrived from <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=28>

Factors Influencing Mental Health

Although treatment of mental disorders has dramatically improved, the cause of most mental illnesses is not well understood. Research has identified a number of biological and sociological factors that contribute to mental health and mental illness. Some of these factors are discussed here.

illnesses; however, many questions remain unanswered. Biological factors associated with mental illness include genetic factors, neurotransmission, and abnormalities of brain structure and functioning.

Genetic Factors

Genetic expressions, combined with neurochemical and metabolic changes and environmental insults, may result in the display of mental disorder characteristics. Genetic testing and counseling offers promise for understanding the complexities associated with gene variation, brain structure, and the physiological response to information processing (Baune and Thome, 2011). There is evidence of predisposition to mental illnesses in families, suggesting that people who have a family member with a mental illness are more likely to experience one themselves. Experts believe that many mental illnesses are linked to abnormalities in many genes, not just one. People may inherit a susceptibility to a mental illness and do not necessarily go on to have a mental illness. Mental illnesses more likely occur from the interaction of multiple genetic factors and some other factors, such as stress, abuse, and traumatic events. These factors can influence, trigger, or exacerbate an illness in a person who has an inherited susceptibility to it.

Abnormalities of Brain Structure and Functioning

Evidence indicates that structural brain abnormalities can be related to some mental illnesses, such as schizophrenia, depression, and Alzheimer's disease. As the science of neuroimaging evolves, a more refined view of the role of brain structure and functioning is unfolding. For example, neuroimaging studies are beginning to explain the role of different central nervous system structures in regulating the hypothalamic-pituitary-adrenal axis that controls responses to stress (Pruessner et al, 2010). Scientists are also recognizing how other systems of the body can impact brain functioning. For example, in one study, researchers found a greater than 60% activation of the amygdala in sleep-deprived subjects than in controls (Pruessner et al, 2010).

Although a number of theories on the etiology of mental disorders have been developed, information is insufficient to establish a definitive biological cause for mental illness. Scholars have concluded that mental disorders are multifactorial, complex phenomena. The important point for community health nurses to understand is that mental illnesses have a very strong biological basis, much like other chronic conditions such as diabetes and heart disease, but that other factors are highly influential.

Social Factors

Some community occurrences and phenomena, such as school shootings, public bombings, bullying, domestic violence, and other tragic events, have identified critical gaps in the need for public education, advocacy, and treatment of mental illness (Bazelon Center, 2013). Throughout history, the symptoms of mental illness have been perceived as permanent, dangerous, frightening, and shameful. People with a diagnosis of mental illness have been described as lazy, idle, weak, immoral, irrational, and too often criminal. On the basis of these characterizations and assumptions, many people with a diagnosis of mental illness have experienced widespread social rejection that may lead to isolation and more social **stigma** (Kondrat and Early 2011).

Another social concern is the tendency of communities to make use of prisons rather than

About half of all people in jails and prisons have mental health problems, and about 65% meet medical criteria for alcohol or other drug abuse and addiction. Prisons are woefully unprepared to provide adequate care to the mentally ill. To help address this problem, in 2008, Senate Bill S. 2304, the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act, was signed into law. This bill provided grants aimed at improving the mental health treatment provided to criminal offenders with a mental illness. Other related initiatives have focused on establishing specialty courts or problem-solving courts. There may be mental health courts in communities to address the needs of the community and those who are charged with a criminal offense and also experience a mental illness (Mental Health America, 2013).

Gender, Racial, and Sexual Orientation Disparities

Racial and ethnic minorities are the fastest-growing communities in the United States. The NIMH's Office for Research on Disparities and Global Mental Health (ORDGMH) is active in reducing mental health disparities. ORDGMH collects local and global mental health disparities data, including movements of populations, global economic relationships, and communication technologies. Culturally diverse groups often bear a disproportionately high burden of disability due to mental disorders. For example, in schizophrenia and mood disorders, there is a high probability of misdiagnosis because of differences in how African Americans express symptoms of emotional distress (APA, 2012).

Because of the lack of access in their communities, Hispanic Americans use mental health services far less than other ethnic and racial groups. This population also constitutes the largest group of uninsured in the United States. American Indian and Alaska Natives experience the higher rates of mental disorders compared to the overall population. These groups experience far greater psychological distress are at greater risk for mental disorders such as depression, substance abuse, anxiety, and PTSD. In some American Indian groups, the rates of alcoholism and illicit drug use disorder are much higher than the U.S. average. Significantly greater percentages of lifetime major depression have been reported among women (11.7%) than men (5.6%). Lifetime percentages of depression reveal ethnic differences: 6.52% among whites, 4.57% among blacks, and 5.17% among Hispanics (APA, 2012).

Although a majority of gay, bisexual, and other men who have sex with men (MSM) have good mental health, there are MSM populations at greater risk for mental health problems. Homosexuality is not a mental disorder. Homophobia, stigma, and discrimination, however, have negative effects on the health of MSM, lesbians, and other sexual minorities. The negative effects of social stigma and discrimination can be found in adolescent and adult MSM. The lesbian, gay, bisexual, and transgendered (LGBT) community are at increased risk for a number of mental health problems. MSM are at increased risk of: major depression, bipolar disorder, and anxiety disorders (Reeves et al, 2011). Lesbian and bisexual women report higher rates of depression and anxiety than other women do. Bisexual women are even more likely than lesbians to have had a mood or anxiety disorder; depression and anxiety in lesbian and bisexual women may be due to stigma, discrimination, rejection, abuse and violence, or being uninsured (Reeves et al, 2011).

Natural and Human-made Disasters and Mental Illness

Natural and human-made disasters, such as hurricanes, floods, violence, terrorism, war, and the

the mental health needs of a community during a disaster but also to maintain vigilance in caring for survivors many years thereafter.

PTSD is highly prevalent among combat veterans returning from war. PTSD is associated with extreme anxiety that can result in suicide. Male veterans in communities are twice as likely to die by suicide as their civilian counterparts (NIMH, 2013) (see Veterans' Health box on suicide). During 2012, there were 60 suicides among active-duty members of the Navy, 59 in the Air Force, and 48 in the Marine Corps. Throughout the U.S. military, suicides increased by nearly 16% from 2011 to 2012 (U.S. Department of Defense, 2012). The Army's suicide rate rose dramatically, as the service reported more than 320 suicides in 2012. The rise in the number of reported suicides prompted the service to take a closer look at its suicide prevention program. Early intervention is key to prevention and treatment. The *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* was released by the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention (USDHHS, 2012) (Box 24-1). This plan is being utilized by the VA (see Veterans' Health box on raising awareness of PTSD).

BOX 24-1 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION

- Create supportive environments that promote healthy and empowered individuals, families, and communities
- Enhance clinical and community preventive services
- Promote the availability of timely treatment and support services
- Improve suicide prevention surveillance collection, research, and evaluation

From U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention: *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC, 2012, Author.

VETERANS' HEALTH: Suicide Among Veterans

A 2010 report by the U.S. Department of Veterans Affairs (VA) states that an estimated 18 veterans die by suicide every day and that there are 950 suicide attempts by veterans every month. Repeated deployments in Iraq and Afghanistan with resulting post-traumatic stress disorder (PTSD) among veterans who served in these theaters are the main reasons for the sharp increases in suicides among veterans aged 19 to 25. The suicide rate is lower for those who are receiving services through the VA. Veterans are less likely to complete treatment if they are male, under age 25, living in a rural area, or receive a diagnosis of PTSD from a primary care provider rather than a mental health program.

Nurses must be aware of the signs of depression and possible suicide and must be knowledgeable about their clients' military status. Always ask whether your client is a veteran and refer him or her to VA resources in the community.

Remember "ACE":

Escort the veteran. Encourage the veteran to get help and provide information on resources available in the community. Escort the veteran to the nearest emergency room or VA facility if he or she is expressing suicidal thoughts or plans.

There are many resources available for veterans in distress. The VA's Veteran's Crisis Line is available 24 hours a day, 7 days a week. Veterans and their families can also access mental health assistance through an online chat at http://www.veteranscrisisline.net/ or by sending a text to 838255 to access assistance 24/7. All of these resources are confidential and connect the veteran or the veteran's family to resources at the VA.

Modified from a presentation created by Bridgette Crotwell Pullis, PhD, RN, CHPN. Data from The U.S. Department of Veterans Affairs: *Mental health,* n.d. Available from <http://www.mentalhealth.va.gov/suicide_prevention/index.asp>.

The global economic crisis that began in late 2008 has had enormous mental health consequences. The sense of hopelessness and powerlessness that accompanied the financial losses associated with dwindling retirement accounts for some, and layoffs for others, has contributed to much emotional distress throughout the world. The World Health Organization (2009), warning that the economic crisis will have a detrimental effect on the mental health of citizens of all nations, called for enhanced monitoring for indications of mental health decline.

VETERANS' HEALTH: Raising Awareness of Post-Traumatic Stress Disorder (PTSD)

The National Center for PTSD sponsored by the U.S. Department of Veterans Affairs is the national clearing house and resource center for PTSD. Veterans and professionals who work with veterans are encouraged to "Take the Step" to raise awareness of PTSD:

Step 1: Learn about PTSD

Symptoms of PTSD:

- Sadness or depression
- Guilt that you did not do more to prevent the trauma
- Shame over your actions during the trauma
- Anger
- Drug or alcohol abuse
- Avoiding people or certain situations

Step 2: Challenge Your Beliefs

Think about the benefits of treatment for PTSD. Realize that treatment is not just for people with severe problems but that treatment can allow everyone suffering from PTSD

symptoms. Getting treatment for PTSD during deployment or immediately after returning home from deployment is optimum.

Step 3: Explore Options

There are many options for treatment and support for PTSD. Veterans may access services through the VA specific to their needs, such as women's mental health services, as well as resources for their families. There are self-help tools available online and through mobile "apps."

Step 4- Reach Out and Make a Difference

- Raise awareness of PTSD
- Support veterans through Joining Forces, About Face, or other community programs
- Learn about PTSD
- Encourage veterans and their families to get treatment and support for PTSD

Modified from a presentation created by Bridgette Crotwell Pullis, PhD, RN, CHPN. Learn all of the facts about PTSD at <http://www.ptsd.va.gov/index.asp>, and learn how veterans with PTSD changed their lives for the better at <http://www.ptsd.va.gov/apps/AboutFace/>.

Political Factors

Political factors can dramatically influence how mental disorders are managed. One significant factor in the politics of mental illness is parity in health care coverage—that is, the equal access to health care for physical and mental illnesses. Historically, health insurance companies have provided less access to treatment for a mental disorder than for a physical disorder. Since 2008, when the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was enacted, there are laws requiring health insurance to cover treatment for mental illness on the same terms and conditions as physical illness. Although this legislation was a victory for mental health, there has been inconsistency in how the the legislation has moved forward.

Health care disparities have become a key issue in public health policy discussions. As previously discussed, members of ethnic minority groups have less access to mental health services than do their white counterparts. Minorities are more likely to delay seeking mental health care and are more likely to receive poor care when they are treated (Stacciarini et al, 2011).

Mental Disorders Encountered in Community Settings

The influence of untreated mental illness on communities and their social structure has been vastly understated. The NIMH estimates that 44.7 million adults aged 18 or older, or 19.8% of all U.S. adults, have experienced any diagnosable mental illness in the past year. Mental illness is one of the leading causes of disability in the United States and mental illness accounts for more than 10% of the disease burden worldwide, ranking it second, following all forms of cardiac disease (USDHHS/SAMHSA, 2012). In the United States, the estimated cost of mental illness exceeds $100 billion for

screening, referring, and follow-up for people with mental health problems in order to meet these mental health needs (Happell and Cleary, 2012).

Overview of Selected Mental Disorders

The *DSM* V (American Psychiatric Association [APA], 2013), classifies mental illnesses and outlines diagnostic criteria for more than 300 disorders. Children with mental disorders are often referred to as children with **severe emotional disorder** (SED). SED disturbance suggests broad ranges of behaviors that might result in classification of a student with SED as eligible for special education. A child with SED may demonstrate emotional disturbance with hallucinations, may have a very short attention span, may hurt others physically, may destroy property, or may have severe presentations of depression, anger, or fear. Among students with SED, externalizing behaviors such as acting out are significantly more prevalent than internalizing behaviors such as withdrawal or depression.

Clinical Example

Michael Nye, a photographer, spent hundreds of hours photographing and taping illness narratives of individuals living with serious mental illness. Viewing his photographs and listening to the accounts of those living with these conditions are valuable experiences for nurses who care for this population (http://michaelnye.org/fineline/index.html). Fleming and colleagues (2009) analyzed the photographs and narratives from the exhibit and concluded that suffering, stigma, and loss of identity were the central experiences depicted by this project.

Schizophrenia

Schizophrenia is the most severe and most profound of all mental illnesses; globally, it affects about 1% of the population (Brain and Behavior Research Foundation, 2013). The effect of this condition on the community is enormous in terms of social and economic burden. To the individual and families affected by schizophrenia, the impact is incalculable. The affected person may present with positive symptoms, including hallucinations, delusions, disorganized thinking and speech, and bizarre behavior, or negative symptoms, such as flat affect, poor attention, lack of motivation, apathy, lack of pleasure, and lack of energy. Onset typically occurs during late adolescence and early adulthood in males and somewhat later in females. There is an increased risk for alcohol use, depression, suicide, and diabetes among persons with schizophrenia. These factors compound the problems associated with living with a psychotic disorder.

Among people diagnosed with schizophrenia, an estimated 20% to 40% attempt suicide; between 5% and 13% actually succeed. Patients with schizophrenia may have **anosignosia** (Treatment Advocacy Center, 2012), an impaired awareness of illness, so they may not recognize that they are ill (Amador, 2007, 2008). This impaired awareness of illness affects approximately 50% of individuals with schizophrenia. Anosignosia contributes to noncompliance with medications and treatment.

Treatment for schizophrenia must be intensive and generally involves hospitalization (initially)

Depression

Depression is the most frequently diagnosed and one of the most disabling mental illnesses in the United States. Depressive disorders affect approximately 18.8 million American adults, or about 9.5% of the U.S. population age 18 and older, in a given year. The disorders include major depressive disorder, dysthymic disorder, and bipolar disorders. Depression often co-occurs with serious physical disorders, such as heart attack, stroke, diabetes, and cancer. About 25% of women and 12% of men have at least one episode of depression during their lifetimes. Although effective treatments exist, most people (almost two thirds) with depressive illness do not seek help (NIMH, 2013). Having a family or personal history of depression, suicide attempt, or sexual abuse, or having current substance abuse or a chronic medical condition increases the risk for depression (APA, 2013). Health education for patients with depression should include risk factor identification as well as when and how to obtain treatment. Symptoms of depression are listed in Box 24-2.

BOX 24-2 SYMPTOMS OF DEPRESSION

- Persistent sad, anxious, or “empty” feelings
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable, including sex
- Fatigue and decreased energy
- Difficulty concentrating, remembering details, and making decisions
- Insomnia, early-morning wakefulness, or excessive sleeping
- Overeating or appetite loss
- Thoughts of suicide, suicide attempts
- Aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment

From National Institute of Mental Health: *Depression* (NIH Publication No. 11-3561), Rockville, MD, 2000, Revised 2011, Author.

RESEARCH HIGHLIGHTS: Measuring Mental Illness–Related Stigma Imposed by Health Care Providers

Knowing that mental illness-related stigma can lead to low rates of seeking help, lack of access to care, under-treatment and social marginalization, Kassam and associates (2012) developed and tested the *Opening Minds Scale for Health Care Providers* (OMS-HC). 787

Data from Kassam A, Papish A, Modgill G, Patten S: The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: The Opening Minds Scale for Health Care Providers (OMS-HC). *BMC Psychiatr* 12:62, 3-12, 2012.

Depression In Children and Adolescents

The incidence of depression in children is 0.9% in preschool-age children, 1.9% in school-age children, and 4.7% in adolescents (Healthy Place, 2013). According to the Centers for Disease Control and Prevention (2013) almost 4% of children 3-17 have ever been diagnosed with depression and as many as 12% of adolescents may have depression. A family history of depression is a major risk factor for childhood depression. Other associated factors that may increase the risk of depression in children and adolescents are a history of verbal, physical, or sexual abuse; frequent separation from, or loss of, a loved one; poverty; mental retardation; attention deficit/hyperactivity disorder; hyperactivity; and chronic illness.

Treatment for depression includes pharmacological therapy, psychotherapy, behavior therapy, electroconvulsive therapy, or a combination of these (APA, 2013; NIMH, 2012). In general, the most effective, first-line treatment is a combination of antidepressant medication and psychotherapy.

Bipolar Disorder

Bipolar disorder refers to a group of mood disorders that manifest as changes in mood from depression to mania. The depressed phase manifests as symptoms seen in major depressive disorder. The manic phase is characterized by a persistent abnormally elevated or irritable mood, impaired judgment, flight of ideas, pressured speech, grandiosity, distractibility, excessive involvement in goal-directed activities, spending few hours sleeping, and impulsivity. These symptoms may co-occur with psychotic features such as hallucinations and delusions. Persons with bipolar disorder are at increased risk for alcohol and substance abuse as well as suicide. The presence of bipolar disorder results in poor occupational and social functioning.

Management of bipolar disorder must be ongoing and must involve close monitoring. Treatment generally involves use of mood-stabilizing medication, often in combination with antipsychotic and antidepressant therapy (APA, 2012). When working with persons with bipolar disorder, nurses need to monitor symptoms and response to psychopharmacological treatment.

Anxiety Disorder

Anxiety disorders are a group of conditions characterized by feelings of anxiety. Anxiety disorders affect up to 16% of the general population at any time. Anxiety disorders may be attributed to the genetic makeup and life experiences of the individual. Some of the more commonly encountered anxiety disorders are generalized anxiety disorder, panic disorder (sometimes accompanied by agoraphobia), phobias, obsessive-compulsive disorder, and PTSD (APA, 2013). They are discussed briefly here.

Generalized Anxiety Disorder

muscle tension, headaches, irritability, sweating or hot flashes, dyspnea, and nausea. Periods of increasing symptoms are usually associated with life stressors or impending difficulties. GAD is probably the most underdiagnosed mental disorder.

Panic Disorder

Approximately 6 million American adults have panic disorder (NIMH, n.d.). **Panic disorder** can occur at any age, but it most often begins in young adulthood (average age, 17-30 years). A panic attack consists of a period of intense fear that develops abruptly and unexpectedly. The initial attack may occur suddenly and unexpectedly while the client is performing everyday tasks. Typically, he or she experiences tachycardia; dyspnea; dizziness; chest pain; nausea; numbness or tingling of the hands and feet; trembling or shaking; sweating; choking; or a feeling that he or she is going to die, go crazy, or do something uncontrolled. It can be extremely frightening. A diagnosis of panic disorder is made when attacks occur with some degree of frequency or regularity.

As the disorder evolves, the anxiety attacks become increasingly frequent and severe, and anticipatory anxiety (fear of having a panic attack) develops. During this phase, events and circumstances associated with the attack may be selectively avoided, leading to phobic behaviors. Thus, the client's life may become progressively constricted.

As the avoidance behavior intensifies, the client begins to withdraw further to avoid being in places or situations from which escape may be difficult or embarrassing or in which help may be unavailable in the event of a panic attack (e.g., church, elevators, movie theaters). The fear of being in these situations or places can lead to **agoraphobia** (literally, fear of the marketplace or open places). Individuals with agoraphobia frequently progress to the point that they cannot leave their homes without experiencing anxiety.

Rates for co-occurring **major depression** range from 10% to 65% in persons with panic disorder (APA, 2013). Cognitive behavioral treatment and short-course benzodiazepines therapy are used to treat panic disorder.

Phobias

A **phobia** is an irrational fear of something (an object or situation), and as many as 8% of Americans are affected by phobias at any given time. Adults with phobias realize that their fears are irrational, but facing the feared object or situation might bring on severe anxiety or a panic attack. Although phobias may begin in childhood, they usually first appear in adolescence or adulthood.

Social phobia, or social anxiety disorder, is a persistent and intense fear of, and compelling desire to avoid, something that would expose the individual to a situation that might be humiliating and embarrassing (APA, 2013). It has a familial tendency and may be accompanied by depression or alcoholism. The most common social phobia is a fear of public speaking. Other examples include being unable to urinate in a public bathroom and not being able to answer questions in social situations. Most people with social phobias can be treated with cognitive-behavioral therapy and medication.

Simple phobias involve a persistent fear of, and compelling desire to avoid, certain objects or

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterized by anxious thoughts and rituals that the individual has difficulty controlling. The person with OCD feels compelled to engage in some ritual to avoid a persistent frightening thought, idea, image, or event. *Obsessions* are recurrent thoughts, emotions, or impulses that cannot be dismissed. *Compulsions* are the rituals or behaviors that are repeatedly performed to prevent, neutralize, or dispel the dreaded obsession. When the individual tries to resist the compulsion, anxiety increases. Common compulsions include hand washing, counting, checking, and touching (APA, 2013). Most individuals recognize that what they are doing is senseless but are unable to control the compulsion. About 2% of Americans are afflicted with OCD, which often appears in the teenage years or early adulthood. Depression and other anxiety disorders often accompany OCD. Behavioral therapy and medication aimed at reducing accompanying symptoms have been found to be helpful.

Post Traumatic Stress Disorder

Post-traumatic stress disorder is a debilitating condition that follows a terrifying event. It affects about 3.5% of U.S. adults. Individuals with PTSD have recurring, persistent, frightening thoughts and memories of their ordeal. The event may involve “shell shock” or “battle fatigue” common to war veterans, a violent attack, serious accident, or natural disaster, or having witnessed a mass destruction or injury, such as an airplane crash. Sometimes the individual is unable to recall an important aspect of the traumatic event. The highest incidence of PTSD occurs among combat-experienced military personnel.

People with PTSD repeatedly relive the trauma in the form of nightmares or disturbing recollections or flashbacks during the day, resulting in sleep disturbances, depression, feelings of detachment or emotional numbness, or being easily startled. They may avoid places or situations that bring back memories (e.g., a woman raped in an elevator may refuse to ride in elevators), and anniversaries of the event are often very difficult. PTSD occurs at all ages and may be accompanied by depression, substance abuse, and/or anxiety. It usually begins within 3 months of the trauma, and the course of the disorder varies. Some individuals recover within 6 months; the condition becomes chronic in others. Infrequently, the illness does not manifest until years after the traumatic event. Treatment includes antidepressants and antianxiety medications and psychotherapy. Support from family and friends can be very beneficial.

Eating Disorders

Eating disorders—anorexia nervosa and bulimia nervosa—are increasingly prevalent in the United States, affecting about 3 million U.S. residents. Anorexia affects about 0.5% to 3.7% of females in their lifetimes (NIMH, 2010), and as many as 4% to 15% of female high school and college women have some symptoms of bulimia.

Eating disorders primarily affect females; males account for 5% to 10% of cases, although the disorders in males may be underreported. Most clients with a diagnosis of eating disorders are white; however, the reason may be socioeconomic factors rather than race. Anorexia and bulimia are often triggered by developmental milestones (e.g., puberty, first sexual contact) or another crisis (e.g., death of a loved one, ridicule over weight, starting college).

one sitting. Snacking throughout the day is not considered bingeing. To lose or maintain weight, the person with bulimia practices purging, which usually involves self-induced vomiting, caused by gagging, using an emetic, or simply mentally willing the action. Laxatives, diuretics, fasting, and excessive exercise may also be employed to control weight.

Bulimia nervosa typically begins in adolescence or during the early 20s, usually in conjunction with a diet. High school and college students, as well as members of certain professions that emphasize weight and/or appearance (e.g., dancers, flight attendants, cheerleaders, athletes, actors, models), are at risk. The condition may lead to electrolyte imbalance, resulting in fatigue, seizures, muscle cramps, arrhythmias, and decreased bone density. Vomiting can damage the esophagus, stomach, teeth, and gums.

The person with **anorexia nervosa** becomes obsessed with a fear of fat and with losing weight. Anorexia nervosa often develops as a fairly gradual decrease in caloric intake. However, the decrease continues until the person is consuming almost nothing. Anorexia usually begins in early adolescence (12 to 14 years is the most common age-group) and may be limited to a single episode of dramatic weight loss within a few months, followed by recovery, or may last for many years.

Risk factors for eating disorders are perfectionism, low self-esteem, stress, poor coping skills, sexual/physical abuse, poor self-image, dependency on others' opinions and deference to others' wishes, and being emotionally reserved. In response to the severely decreased caloric intake, the body tries to compensate by slowing down body processes. Menstruation ceases; blood pressure, pulse, and respiration rates slow; and thyroid activity diminishes. Electrolyte imbalance can become very severe. Other symptoms are mild anemia, joint swelling, and reduced muscle mass. Anorexia nervosa can be life threatening and has a mortality rate of 5% to 21%.

Treatment for eating disorders involves long-term nutrition counseling, psychotherapy, and behavior modification. Hospitalization may be required for clients with serious complications. Self-help groups and support groups can be very beneficial for both the client and the family.

Nurses need to be aware of the resources available from the American Academy of Child and Adolescent Psychiatry (AACAP), which has a section for families and youth. Such knowledge is important, as community health nurses assess the social influences that contribute to the condition.

Attention Deficit/Hyperactivity Disorder

Two of the most common conditions encountered by nurses who work with children in community settings are **attention-deficit/hyperactivity disorder** (ADHD) and **attention deficit disorder** (ADD). About 11% of school-age children in the United States—and 19% of high school–age boys—have been diagnosed ADHD, according to CDC data. Behaviors that might indicate ADHD/ADD usually appear before age 7 years and are often accompanied by related problems, such as learning disability, anxiety, and depression. The three major characteristics of ADHD/ADD are inattention, hyperactivity, and impulsivity.

The cause of ADHD/ADD is not known, but it is important to note that the disorder is not caused by minor head injuries, birth complications, food allergies, too much sugar, poor home life, poor schools, or too much television watching. Maternal substance use and abuse (e.g., alcohol,

Although parents may notice symptoms and signs, it is often teachers who recognize the behaviors consistent with attention deficit disorders and suggest referral for assessment and treatment (NIMH, 2013. Experts caution that diagnosis of attention disorders should be made following a comprehensive physical, psychological, social, and behavioral evaluation and should not be based solely on anecdotal reports from parents or teachers. The evaluation should rule out other possible reasons for the behavior (e.g., emotional problems, poor vision or hearing, physical problems) and should include input from teachers, parents, and others who know the child well. Intelligence and achievement testing may also be performed to rule out or identify a learning disability.

Symptoms of ADHD/ADD are typically managed through a combination of behavior therapy, emotional counseling, and practical support. Use of medication is now becoming increasingly commonplace in the management of ADHD/ADD. It is very important, however, that children with attention disorders and their families understand that medication does not cure the disorder; it just temporarily controls symptoms.

Stimulants have been shown to be successful in treating attention disorders. The most commonly used medications are methylphenidate (Ritalin) and amphetamines. Appetite suppression and poor sleep are common side effects.

Suicide

There are approximately 1 million deaths by suicide per year throughout the world. The Centers for Disease Control and Prevention (2012) reported there were more than 38,000 deaths by suicide in the United States in 2010. Suicide is the third leading cause of death among those aged 15 to 24 years. The highest rate of suicide occurs in males older than 65 years; white males older than 85 years are particularly vulnerable.

Historically, risk and protective factors have been used to identify those at highest risk for suicide. The American Association of Suicidology (AAS) (2013) has recommended recognition of warning signs as more relevant than risk and protective factors in preventing death by suicide. The AAS has organized the warning signs according to the easily remembered mnemonic, IS PATH WARM (Table 24-2). Warning signs that indicate acute risk for suicidality may be observed in individuals who are threatening to hurt or kill themselves, attempting to identify access to lethal weapons or other means that could result in death, or communicating about dying when these thoughts or actions are out of the ordinary for them.

Risk factors include previous suicide attempts, mental illness, substance abuse, and barriers to accessing mental health treatment. Protective factors may decrease the risk of suicide include appropriate mental health care, easy access to treatment, community support, and continuing support from medical and mental health care providers. Box 24-3 lists protective factors and risk factors that all community health nurses should recognize, and Box 24-4 provides warning signs of suicide.

TABLE 24-2 Suicide Warning Signs: "IS PATH WARM"

Ideation	Does the person state that he or she is having thoughts of suicide?
Substance abuse	Is the person demonstrating increased use of alcohol or drugs?
Purposelessness	Does the person state that he or she feels as if there is no purpose in his or her life?
Anxiety	Is the person demonstrating anxiety-related behaviors such as: talking about being overly worried about things, ruminating, difficulty concentrating, or exhibiting increased psychomotor agitation?
Trapped	Does the person state that he or she feels trapped, that there is no way out of the current situation except to die?
Hopelessness	Does the person state that he or she feels hopeless? Is the person able to describe something to look forward to?
Withdrawal	Is the person withdrawing from others such as family and friends? Is the person isolating?
Anger	Is the person demonstrating uncontrolled anger? Is the person acting with rage or seeking revenge?
Recklessness	Is the person engaged in risk-taking behaviors? Is the person acting as if he or she "doesn't care" or isn't thinking about the consequences of the risk-taking behavior?
Mood changes	Is the person experiencing dramatic mood changes?

From American Association of Suicidology: *Know the warning signs*, 2009. Retrieved from <http://www.suicidology.org>. Contact information: American Association of Suicidology 5221 Wisconsin Ave. NW 2nd Floor Washington, DC 20015-2032 Phone (202) 237-2280 Fax (202) 237-2282 www.suicidology.org info@suicidology.org

Thus, it is important that all community health nurses become familiar with assessing for suicide warning signs and accessing appropriate resources. Nurses should refer the person exhibiting suicide warning signs to a mental health clinic or provider as soon as possible. This may involve taking emergency action by calling the local emergency services number in the community and staying with the person until help arrives. Table 24-3 provides a list of suicide information resources.

Identification and Management of Mental Disorders

Early identification, appropriate treatment, and rehabilitation can significantly reduce the duration and level of disability associated with mental disorders and decrease the possibility of relapse. Interventions to promote mental health and decrease mental disorders include focusing on decreasing stressors and/or increasing the capacity of the individual to cope with stress. Other interventions include the use of pharmacological agents and psychosocial interventions such as strengthening interpersonal, psychological, and physical resources through counseling, support groups, and psychoeducation.

BOX 24-3 SUICIDE: PROTECTIVE FACTORS AND RISK FACTORS

Protective Factors

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

Risk Factors

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Adapted from Substance Abuse and Mental Health Services Administration, National Suicide Prevention Lifeline: *Risk factors for suicide,* n.d. Available from <http://www.suicidepreventionlifeline.org/learn/riskfactors.aspx>

BOX 24-4 WARNING SIGNS OF SUICIDE

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

From Suicidepreventionlifeline.org: *When it seems like there is no hope, there is help* (Brochure CMHS-SVP-0141), 2006. Available from <http://www.cbp.gov/linkhandler/cgov/careers/benefits_employees/frc/suicide_prevention/suicide_prevention_materials/prevention_brochure.ctt/prevention_brochure.pdf>.

TABLE 24-3 Suicide Prevention and Referral Resources

National Suicide Prevention Lifeline	1-800-273-TALK (8255) www.suicidepreventionlifeline.org/
American Association of Suicidology	www.suicidology.org/home
Suicide Prevention Resource Center	www.sprc.org/
Suicide Awareness Voices of Education	www.save.org/
Suicide Prevention: A Resource Manual for the Army	http://www.armyg1.army.mil/dcs/docs/Suicide%20Prevention%20Manual.pdf
Veterans Crisis Line	1-800- 273- 8255 Text to 838255 www.veteranscrisisline.net/ChatTermsOfService.aspx?account=Veterans%20Chat
American Foundation for Suicide Prevention	www.afsp.org/
Local emergency resource	Dial 911

The accessibility of mental health service is pivotal in promoting and maintaining the health. Decreased funding for services, managed care limitations on mental health coverage, and the inequality of coverage by the insurance industry have caused downsizing or forced closure in the traditional places of treatment, such as community mental health centers and community hospitals. Consequently, the accessibility to community mental health services has become an issue of significant concern. In addition, the symptoms of mental illness often interfere with an individual's ability to access services. Alterations in thoughts and perceptions, anxiety, and decreased energy are common symptoms of mental illness, all of which interfere with negotiating the complex systems that currently surround the provision of mental health services. This section describes actions that may be taken by community health nurses to identify mental illness and outlines potential treatment options.

Identification of Mental Disorders

Whether the nurse is working in a physician's office, a community clinic, a school, or home health and hospice, occupational health, or other setting, recognition of signs and symptoms that might indicate a mental disorder is an important component of practice. More than ever, public health nurses work in collaboration with crisis housing agencies and school district managers for homeless families. In these situations, the nurse should continue to assess for other signs and symptoms that might indicate a mental disorder and should be prepared to intervene if they appear.

Often, the assessment process includes direct questioning or observation. At other times, a standardized assessment tool or questionnaire might be employed. Figures 24-1 and 24-2 contain examples of instruments that are available to elicit information about symptoms of anxiety or depression. Whenever using these or other screening tools, the nurse should be prepared in

Evidence-Based Practice Management of Mental Disorders

The website of the Substance Abuse and Mental Health Services Agency's (SAMHSA) National Registry of Evidence Based Programs and Practices (NREPP) lists EBP programs and interventions that demonstrate positive outcomes in community mental health. The goals of treatment for mental illness are to reduce symptoms, improve occupational and social functioning, develop and strengthen coping skills, and promote behaviors to improve the individual's life. Crisis housing programs, supportive employments programs, Assertive Community Treatment (ACT) team models, **Crisis Intervention Team** (CIT) models, psychotropic medication management programs, community **case management** programs, mobile crisis units, Cognitive Behavioral Intervention for Trauma in Schools programs, and many more are listed. Basic approaches to the treatment of mental disorders are detailed; see the website <http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=smi>.

Psychotropic or Psychotherapeutic Medications

Psychotropic/psychotherapeutic medications treat symptoms of mental illness. The appropriateness of psychopharmacological agents and their prescribed regimen depends on the diagnosis, side effects, and client response. Some of the psychotropic medications prescribed are classified as antipsychotics, antidepressants, mood stabilizers, anticonvulsants, antianxiety agents, and hypnotics. Information about medication profiles and treatment regimens often changes as new information becomes available, so nurses should be aware of up-to-date medication information from Internet resources such as www.nlm.nih.gov/medlineplus/druginformation.html or www.rxlist.com.

Psychotherapy

Psychotherapy refers to a process of discovery that helps alleviate troubling emotional symptoms and assists individuals in returning to a healthy life (APA, 2013). In nursing, psychotherapy is an intervention used predominantly by psychiatric/mental health advanced practice nurses. Psychotherapy involves the use of a professional, therapeutic relationship and the application of psychotherapy theories and best practices to change a client's attitudes, feelings, beliefs, defenses, personality, and behaviors. Therapy approaches vary among schools of psychotherapy and with the nature of the client's problem. Psychotherapy is often used in conjunction with medication to treat many mental disorders. Various types of psychotherapy include the following (NIMH, 2014):

Individual therapy focuses on the client's current life and relationships within the family, social, and work environments.

Family therapy involves problem-solving sessions with members of a family.

FIGURE 24-1 Center for Epidemiologic Studies depression scale. Interpretation: A total score of 22 or higher is indicative of depression when the scale is used in primary care.

During the Past Week	Rarely or None of the Time (Less than 1 Day)	Some or a Little of the Time (1-2 Days)	Occasionally or a Moderate Amount of the Time (3-4 Days)	Most or All of the Time (5-7 Days)
1. I was bothered by things that don't usually bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with the help of my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	3	2	1	0
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	3	2	1	0
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	3	2	1	0
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	3	2	1	0
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get "going."	0	1	2	3

(From Radloff LS: The CES-D scale: a self-report depression scale for research in the general population, *Appl Psychol Meas* 1:385-401, 1977. Copyright 1977, West Publishing Company/Applied Psychological Measurement, Inc.)

Couple therapy is used to develop the relationship and minimize problems through understanding how individual conflicts are expressed in the couple's interactions.

Group therapy involves a small group of people with similar problems who, with the guidance of a therapist, discuss individual issues and help one another with problems.

Cognitive-behavioral therapy may be used in individual, family, couples, or group therapy. The goal is to identify and correct distorted thought patterns that can lead to troublesome feelings and behaviors.

Behavioral therapy uses learning principles to change thought patterns and behaviors systematically; it is used to encourage the individual to learn specific skills to obtain rewards and satisfaction.

FIGURE 24-2 Social readjustment rating scale. *LCU,* Life change unit(s).

Rank	Life Event	Mean Value	Rank	Life Event	Mean Value
1	Death of spouse	100	23	Son or daughter leaving home	29
2	Divorce	73	24	Trouble with in-laws	29
3	Marital separation	65	25	Outstanding personal achievement	28
4	Jail term	63	26	Wife begins or stops work	26
5	Death of close family member	63	27	Begin or end school	26
6	Personal injury or illness	53	28	Change in living conditions	25
7	Marriage	50	29	Change in personal habits	24
8	Fired at work	47	30	Trouble with boss	23
9	Marital reconciliation	45	31	Change in work hours or conditions	20
10	Retirement	45	32	Change in residence	20
11	Change in health of family member	44	33	Change in schools	20
12	Pregnancy	40	34	Change in recreation	19
13	Sex difficulties	39	35	Change in church activities	19
14	Gain of new family member	39	36	Change in social activities	18
15	Business readjustment	39	37	Mortgage or loan less than $10,000	17
16	Change in financial state	38	38	Change in sleeping habits	16
17	Death of close friend	37	39	Change in number of family get-togethers	15
18	Change to different line of work	36	40	Change in eating habits	15
19	Change in number of arguments with spouse	35	41	Vacation	13
20	Mortgage over $10,000	31	42	Christmas	12
21	Foreclosure on mortgage or loan	30	43	Minor violations of the law	11
22	Change in responsibilities at work	29			

Life Crisis Categories and LCU Scores*

No life crisis	0-149
Mild life crisis	150-199
Moderate life crisis	200-299
Major life crisis	300 or more

*The LCU score includes those life event items experienced during a 1-year period.

(From Holmes TH, Rahe RH: The social readjustment rating scale, *J Psychosom Res* 11:213-217, 1967, Elsevier Science Inc.)

Psychotherapy may be short-term or long-term, depending on the nature of the problem and the availability of resources.

Community-Based Mental Health Care

Over the past several decades, there have been a number of initiatives directed toward improving and promoting community-based care of those with mental illness. One of those initiatives is the President's New Freedom Commission on Mental Health (NFCMH). The New Freedom Initiative

determined that in a transformed mental health system, the following would be true (NFCMH, 2003, p. 8):

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered, and research is accelerated.
6. Technology is used to access mental health care and information.

The commission acknowledged that mental illness comprises the only type of illness that defies a comprehensive delivery approach. The commission called for a shift in the fragmented system to an integrated comprehensive approach to mental health care delivery. Table 24-4 provides an overview of the recommendations of the commission. One of the areas addressed by the commission pertained to the need for school-based mental health (SBMH) programs. In an overview of key elements related to SBMH, Paternite and Johnston (2006) identified the need for (1) partnerships between and among schools, families, and communities; (2) a pledge to support a full continuum of mental health services that include education, health promotion, assessment, and early intervention; and (3) services for all children and adolescents.

TABLE 24-4 Goals and Recommendations of the New Freedom Commission on Mental Health

GOAL	RECOMMENDATIONS
1. Americans understand that mental health is essential to overall health.	Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. Address mental health with the same urgency as physical health.
2. Mental health care is consumer and family driven.	Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. Involve consumers and families fully in orienting the mental health system toward recovery. Align relevant federal programs to improve access and accountability for mental health services. Create a comprehensive state mental health plan. Protect and enhance the rights of people with mental illnesses.
3. Disparities in mental health services are eliminated.	Improve access to quality care that is culturally competent. Improve access to quality care in rural and geographically remote areas.
4. Early mental health screening, assessment, and referral to services are common practice.	Promote the mental health of young children. Improve and expand school mental health programs. Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. Screen for mental disorders in primary health care across the lifespan, and connect to treatment and support.
5. Excellent mental health care is delivered and research is accelerated.	Accelerate research to promote recovery and resilience and ultimately to cure and prevent mental illnesses. Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. Improve and expand the workforce providing evidence-based mental health services and supports. Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
6. Technology is used to access mental health care and information.	Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in

From New Freedom Commission on Mental Health: *Achieving the promise: transforming mental health care in America, Final report* (USDHHS Pub No SMA 03-3832), Rockville, MD, 2003, Author. Also available from <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf>.

ETHICAL INSIGHTS: Valuing Human Beings

A study by Eriksen and colleagues (2012) demonstrates how users of mental health services describe and make sense of their meetings with other people. Acknowledging and valuing one other is an essential human characteristic that promotes individual dignity and vulnerability in relationships. The group utilized the Interpretative Phenomenological Analysis (IPA) to explore peoples' relationship to the world and how they make sense of their life experiences. Participants represented people living with mental health problems who depended on others for support and help in their everyday lives. Participants often would report the process "to be recognized" as a phenomenon in their life. To be recognized as a human being and be recognized as a human being struggling with a chronic mental health problems was helpful in their struggle in *self-preservation*. Mental health professionals may be challenged to recognize the struggle of the person with a serious mental illness (SMI). Mental health professionals can be helpful and instrumental in health promotion with SMI populations.

Data from Eriksen KA, Sundfor B, Karlsson B, et al: Recognition as a valued human being: Perspectives of mental health service users, *Nursing Ethics* 19(3) 357–368, 2012.

In an earlier initiative, the Center for Mental Health Services (CMHS) was formed in the early 1990s to improve prevention and mental health treatment services for all Americans. The CMHS helps states improve and increase the quality and range of treatment, rehabilitation, and support services for people with mental health problems, their families, and their communities (SAMHSA, 2014).

One of the programs promoted by the CMHS is the Community Support System. The Community Support System uses case management strategies to comprehensively provide care for those with serious mental illness. Components of the Community Support System include client identification and outreach, mental health treatment, crisis response service, health and dental care, housing, income support and entitlement, peer support, family and community support, rehabilitation services, and protection and advocacy. The case management approach serves to link the service system to the client and to coordinate their service received (Kondrat and Early, 2011). Other initiatives and programs sponsored by the CMHS are listed in Table 24-5.

The **Assertive Community Treatment (ACT)** model is another example of a community-based initiative to help meet the needs of those with mental illness. ACT, which has been in existence since the late 1960s, has become the exemplar of community mental health treatment models. The ACT program moves the traditional 24-hour treatment model of acute care settings into the community and serves people with mental illness in a highly individualized fashion (National Alliance on Mental Illness [NAMI], 2013). The ACT model provides supportive therapy, mobile crisis intervention, psychiatric medications, hospitalization, education, and skill teaching for

TABLE 24-5 Center for Mental Health Services: Examples of Programs and Initiatives

PROGRAM/INITIATIVE	PURPOSE AND ACTIVITIES
Prevention of substance abuse and mental illness	Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide.
Trauma and justice	Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.
Military families	Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.
Recovery support	Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.
Health reform	Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions.
Health information technology	Ensuring that the behavioral health system, including states, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records.
Data, outcomes, and quality	Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.
Public awareness and support	Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

From Substance Abuse and Mental Health Services Administration, *Leading change: A plan for SAMHSA's roles and actions 2011-2014* (HHS Publication No. [SMA] 11-4629), Rockville, MD, 2011, Substance Abuse and Mental Health Services Administration. Also available from <http://store.samhsa.gov/shin/content//SMA11-4629/01-FullDocument.pdf>.

BOX 24-5 KEY FEATURES OF THE ASSERTIVE COMMUNITY TREATMENT (ACT) PROGRAM

- Hospitalization
- Substance abuse treatment
- Behaviorally oriented skill teaching
- Supported employment
- Support for resuming education
- Collaboration with families and assistance to clients with children
- Direct support to help clients obtain legal and advocacy services

pilot project (NAMI, 2013). Box 24-5 gives additional details about ACT programs.

The **Crisis Intervention Team** (CIT) program originates from the Memphis Model, an educational and advocacy training program. The Memphis Police Department joined with the Memphis Chapter of the NAMI, mental health providers, the University of Memphis, and the University of Tennessee in organizing, training, and implementing a specialized unit. CIT programs partner with **mental health consumers** and family members, mental health professionals, and advocacy organizations. Law enforcement personnel are trained in developing a more intelligent, understandable, and safe

BOX 24-6 CORE ELEMENTS OF CRISIS INTERVENTION TEAMS (CITS)

Ongoing Elements

1. Partnerships: law enforcement, advocacy, mental health
2. Community ownership: planning, implementation & networking
3. Policies and procedures

Operational Elements

4. CIT: officer, dispatcher, coordinator
5. Curriculum: CIT training
6. Mental health receiving facility: emergency services

Sustaining Elements

7. Evaluation and research
8. In-service training
9. Recognition and honors
10. Outreach: developing CIT in other communities

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approach to mental crisis events. (See Box 24-6 for the core elements of the Crisis Intervention Team).

Specialty courts—also called treatment courts, accountability courts, and problem-solving courts—deal with a number of problem areas within the criminal justice system. These specialty courts can deal with adult, juvenile, users, and family drug problems, mental health disorders, military veterans, and people found to be driving under the influence (DUI) of

TABLE 24-6 Organizations that Promote Education and Advocate for Mental Health

RESOURCE	SERVICES	CONTACT INFORMATION
Substance Abuse and Mental Health Services Administration (SAMHSA)	Programs, policies, information and data, contracts and grants Vision: Behavioral health is essential for health, prevention works, treatment is effective, people can recover from mental illness diagnosis and substance abuse	http://www.samhsa.gov/
National Alliance on Mental Illness (NAMI)	Consumer education regarding various mental health disorders, medication and treatment, research, public policy issues; links to find support at state and local level including support groups and online discussion groups; tips for becoming politically involved in mental health public policy issues	http://www.nami.org/
Mental Health America (MHA)	Inform, advocate and enable access to quality behavioral health services for all Americans	http://www.mentalhealthamerica.net/
National Institute of Mental Health (NIMH)	Education on mental health topics and research Vision: Understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure	http://www.nimh.nih.gov/index.shtml
Depression and Bipolar Support Alliance	Education on depression and bipolar disorder; online discussion and support groups; assistance in finding treatment resources	http://www.dbsalliance.org
National Education Alliance for Borderline Personality Disorder	Education about borderline personality disorder and treatment	www.borderlinepersonalitydisorder.com/
Obsessive-Compulsive Foundation	Education about obsessive compulsive and anxiety disorders and treatment	www.ocfoundation.org/
Postpartum Support International	Education and resource information for individuals experiencing symptoms of prenatal or postpartum mood or anxiety disorders	http://postpartum.net/
U.S. Department of Veteran Affairs National Center for PTSD	Public and professional sections for education, training materials as well as information and tools to help you with assessment and	http://www.ptsd.va.gov/

Brain and Behavior Research Foundation, formerly called National Association for Research on Schizophrenia And Depression (NARSAD)	Alleviating the suffering caused by mental illness by awarding grants that will lead to advances and breakthroughs in scientific research	http://bbrfoundation.org/
National Council for Community Behavioral Healthcare	Behavioral health care, holistic approach to meet needs of the individuals and families	www.thenationalcouncil.org/cs/home

alcohol or drugs. These programs incorporate assessment and screening to examine problematic behavior due to mental health problems and substance abuse. Specialty courts provide education regarding mental and substance use disorders and medication monitoring and drug testing.

Role of the Community Mental Health Nurse

More than ever, there are opportunities for the community mental health nurse to make a difference. For the psychiatric–mental health nurse there are EBP models of care providing promising outcome in communities. Applications of the nursing process are and always can be facilitated to help special populations affected by mental illness in the community. There certainly are challenges to the effective provision of mental health services in the community, such as accessibility, disparity, and cost. When nurses are providing care to individuals, families, groups, and communities, there is a hope for change, progress, and improved health promotion for everyone. In spite of multiple challenges, the role of a community mental health nurse can be extremely rewarding (Sheerin, 2011). Perhaps the most critical impact made by nurses in community settings is through the establishment of interpersonal relationships with the community as professional, knowledgeable, responsible care providers (Happell et al, 2011, 2012).

Community mental health nursing roles are multidimensional (e.g., participant in mental health courts, veterans courts, other specialty or problem-solving courts; educator, researcher, collaborator, consultant, case managers, content expert, administrator, activist, politician, advocate, initiator, evaluator, grant writer, practitioner, and coordinator). Mental health nurses serve on ACT, Crisis Intervention, community case management, mobile crisis, and crisis housing coordination teams. Community mental health nurses as educators and activists dispel myths, provide accurate information about mental illness, and influence policy and legislation advocating for those with mental illness.

As practitioner and coordinator, the nurse works directly with individuals, groups, and families. Besides intervening to assist consumers in controlling or alleviating the symptoms of mental illness, the practitioner and coordinator also helps the consumer “navigate” the segmented web of agencies and other service providers. A list of organizations that advocate for mental health is shown in Table 24-6. Community mental health nurses not only take action to solve an immediate problem but also plan and intervene to ensure safety, continuity, and quality of care for consumers. Therefore, the practitioner and coordinator roles require skills in anticipating and evaluating the actions of other providers and communicating with consumers, families, rehabilitation services, and government or social agencies.

Within this aspect of community mental health nursing, individual-, family-, and community-level crises are anticipated and prevented or, failing these, contained. For example, as practitioners and coordinators, nurses might organize people taking psychotropic medications to share experiences

community mental health nurses work toward matching consumers and families with culturally appropriate and sensitive providers to achieve the “best fit.”

CASE STUDY APPLICATION OF THE NURSING PROCESS

Joseph Green, a divorced 52-year-old veteran of Operation Iraqi Freedom, was discharged from the hospital with a referral to cardiac rehabilitation. Joseph has a ventricular pacemaker that was inserted 2 years ago. Last week he was brought into the emergency department for failure of the pacemaker. He was experiencing syncope and hypotension. His pacemaker was corrected and he was discharged back into the community, where he is currently living at a men’s shelter.

Joseph has a history of a congestive heart failure (CHF), depression, alcoholism, chronic obstructive pulmonary disease (COPD), traumatic brain injury (TBI), and posttraumatic stress disorder (PTSD). He has prescriptions for citalopram, carvedilol, and an Advair inhaler. He admits to being noncompliant at times with taking his prescriptions. He has access to health care services from the nearest VA medical center, which is 350 miles away. He takes a Disabled American Veterans (DAV) van to the medical center once or twice a month where he fills his prescriptions and sees mental health counselors. There is cardiac rehabilitation at the center, but Joseph does not want to go as often as the VA doctors have recommended. Joseph has no income and cooks meals at the men’s shelter for his room and board. Because he cannot drink alcohol at the shelter, he has been abstinent for 9 months. He smokes a pack of cigarettes daily when he has cigarettes.

Joseph has difficulty sleeping most nights and awakens from nightmares. He was diagnosed with major depression and PTSD 5 years ago and reports having suicidal thoughts occasionally. He has been estranged from his grown children for several years. He has a sister living in the same city and his relationship with her strained. The Assertive Community Treatment (ACT) team makes visits to the shelter to assist other men, and Joseph has inquired how to become a consumer of ACT services. There is a local veterans’ support group at the Veterans of Foreign Wars (VFW) building that Joseph and others from the shelter go to several nights a week.

Assessment

On his first trip to the VA medical center after his recent discharge, the outpatient clinic nurse notes that Joseph was noncompliant with his mediations only 2 days the previous week. He reports that he is not depressed, and he denies having suicidal thoughts. He has had no syncope or chest palpations.

Diagnosis

Individual

- History of mental illness (depression, PTSD, and alcoholism)
- Difficulty following treatment regimen
- Less than adequate social skills
- Poor self-worth

Family and Social Relationships

- Inability to communicate with family members effectively
- Jeopardy of reoccurring homelessness

Planning

Planning for Joseph is primarily through collaboration in the community where he resides at the men's shelter. His relationships with others at the shelter and the VFW are important. The staff at the men's shelter are familiar with the VA's homeless program information: 1-877-4AID-VET (1-877-424-3838) and http://www.va.gov/HOMELESS/for_homeless_veterans.asp.

The men's shelter also supports Joseph by helping him get to the DAV van when he has appointment at the VA medical center. The shelter offers chaplain services and also utilizes the community Crisis Intervention Team (CIT) law enforcement officers at times to help talk with residents when they are experiencing stress or need de-escalation of their behavior. A CIT officer who is a veteran stops in once in awhile to see the men as a proactive visit.

Individual

Long-Term Goal

- Joseph will progress with community supportive services and relationships with people

Short-Term Goals

- Joseph will remain medication compliant
- Joseph will remain abstinent from alcohol

Family and Social Relationships

Long-Term Goals

- Safe housing
- Compliance with medications
- Sobriety
- Case management with ACT Team and VA

Short-Term Goals

- Working with shelter staff and ACT Team
- Sobriety
- Compliance with medications

Intervention

The staff at the men's shelter meet with Joseph regularly to evaluate compliance with medications. The staff also will know when his appointments are at the VA in order to plan transportation on the DAV van. The relationships that Joseph has with other veterans is helpful in a support milieu.

Individual

- Joseph has agreed to work with the staff at the shelter in a team effort to keep him in safe housing. He has agreed to work with the ACT Team, VA case management, and his Alcoholics Anonymous (AA) community.

Family and Social Relationships

- Joseph will continue to work with VA case management, the ACT Team, and the staff at the shelter.
- He will call his sister weekly.

Evaluation

Joseph verbalized understanding of the importance of safe housing, the ACT Team intervention, and social relationships with VA peers and AA peers. He also agreed to call his AA or VA contact when needed if he is beginning to feel agitated or wanting to isolate himself. The ACT Team will consistently contact Joseph and be available on weekends. Joseph has agreed to give permission for the ACT Team to report his status to the VA case managers.

Levels of Prevention

Primary

- Maintaining housing at shelter
- Assisting Joseph with compliance with medications

Secondary

- Encouraging maintenance of social relationships (shelter staff, other veterans, AA peers) and relationship with sister

Tertiary

- Monitoring of medical health status and psychological health status
- Group therapy at AA meetings and the VA medical center

Summary

Improved information and EBP may result in greater understanding of the factors that contribute to mental disorders and lead to more effective treatment.

As discussed in this chapter, the vast majority of individuals with diagnosable mental disorders are found in the community, and many, if not most, never seek professional help. The framework for community mental health nursing presented in this chapter should prove useful in improving the lives of individuals, families, and groups of people with mental illness. Further, it is hoped that all nurses will become advocates for the mentally ill and will support social and political change to improve the mental health of all.

Learning Activities

1. Reflect on your personal experience interacting with individuals with mental illness. What thoughts or feelings did these experiences produce? What are several issues that nurses can advocate for in caring for this special population?
2. Locate the National Alliance for Mental Illness (NAMI) and Suicide Prevention Action Network (SPAN) chapters in your community. What services do these agencies offer? How might those services be helpful in the community mental health nursing role?
3. List five topics or issues for which the community mental health nurse can facilitate individual, family, or group education about in the community.

EVOLVE WEBSITE

http://evolve.elsevier.com/Nies

- NCLEX Review Questions
- Case Studies
- Glossary

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