Prevention
Primary, secondary and especially tertiary prevention had been largely neglected. There is now, though, promotion of social integration and employment of individuals with mental illness in their community. Special focus should be placed on the mental health needs of children, adolescents and the elderly.

Adequate resources
A system with adequate resources must be created to support better quality of care and more consumer-driven services. This should actually reduce overall spending on mental health.

Community-based care
Most chronic beds in psychiatric hospitals should be eliminated or transformed to social health beds. Specialised secure departments for the compulsory long-term treatment of non-voluntary patients are planned in psychiatric hospitals.

Integration
Mental healthcare is due to be better integrated into general health and social services, as care shifts away from psychiatric hospitals to psychiatric departments in general hospitals.

Local participation
Local government must be involved in health promotion, and in the treatment, rehabilitation and integration of patients into the community and labour market.

Training
New curricula will be needed for the transformation to community mental healthcare, which will require both traditional and new categories of personnel: social workers, case managers, primary care physicians, self-help group workers, patient advocates and advocacy experts.

References

Bražinová, A., Baudiš, P., Háva, P., *et al* (2008) Mental health policies and legislation. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 81–112. Charles University Press.

Heretik, A., Sr, Heretik, A., Jr, Novotný, V., *et al* (2003) *EPID – Epidemiológia depresií na Slovensku*. [Epidemiology of Depression in Slovakia.] Psychoprof.

Nawka, P., Dragomirecká, E., Dzúrová, D., *et al* (2008) Organizational structures. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 113–141. Charles University Press.

NCZI (Národné Centrum Zdravotníckych Informácií; National Health Information Centre) (2009) *Zdravotnícka Rocenka Za Rok 2008*. [Health Yearbook Year 2008.] NCZI.

Novotný, V., Heretik, A., Sr, Heretik, A., Jr, *et al* (2006) *EPIA – Epidemiológia Vybraných Uzkostných Porúch na Slovensku.* [Epidemiology of Selected Anxiety Disorders in Slovakia.] Psychoprof.

Pažitný, P. (2008) *Stanovisko HPI k Rozpoctu Zdravotníctva na Roky 2009–2011*. [Health System Budget 2009–2911 from the Standpoint of the Health Policy Institute.] Available at http://www.hpi.sk/hpi/sk/view/2213/stanovisko-hpi-k-rozpoctu-zdravotnictva-na-roky-2009-2011.html (accessed August 2010).

UZIS (Ústav Zdravotnických Informací a Statistiky; Institute of Health Information and Statistics) (2006) *Trendy Vývoje Zdravotnických Dat v SR a CR v Letech 1994–2004*. [Trends in Evolution of Health Data in the SR and CR, 1994–2004.] UZIS.

Veselý, A. & Ocvár, L. (2008) Research and evaluation. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 225–250. Charles University Press.

Vevera, J., Bražinová, A., Nemec, J., *et al* (2008) Human resources and training. In *Mental Health Care Reform in the Czech and Slovak Republics, 1989 to the Present* (eds R. M. Scheffler & M. Potucek), pp. 197–223. Charles University Press.

World Health Organization (2010) Slovakia. Country cooperation strategy at a glance. Available at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_svk_en.pdf

COUNTRY PROFILE

Psychiatry in the USA: an overview

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The USA has the world's largest economy and the highest per capita spending on healthcare, but it lags behind other countries on a number of key health measures. It ranks 23rd in healthy life expectancy and 32nd in infant mortality (World Health Organization, 2009). In 2000, the World Health Organization ranked the US healthcare system as 1st in responsiveness, 37th in overall performance, and 72nd by overall level of health (among 191 member nations in the study).

Mental health in the USA

Approximately 25% of US adults have a diagnosable mental disorder in a given year and approximately 6% have a serious mental illness. Mental disorders are the leading cause of disability for people aged 15–44 years (National Institute of Mental Health, 2010).

About 11% of adults experience serious psychological distress, such as anxiety and mood disorders, that result in

functional impairment that impedes one or more major life activities. Rates of mental illness are highest for adults aged 18–25 years and lowest for those over 50; rates for women are significantly higher than for men. The most common mental illnesses are anxiety and mood disorders (Substance Abuse and Mental Health Services Administration, 2009).

Some 17% of inmates entering jails and prisons have a serious mental illness (which is nearly three times the rate in the general population) (Steadman *et al*, 2009). As many as 70% of those in the juvenile justice system have a diagnosable mental disorder and one in five has a mental disorder significant enough to impair functioning (Skowyra & Cocozza, 2006).

Unfortunately, the high rate of mental illness does not correlate with adequate treatment. Fewer than half of adults with a diagnosable mental disorder receive treatment in a given year (Kessler *et al*, 2005). The number of Americans under care for mental illnesses nearly doubled between 1996 and 2006 (from 19 to 36 million) (Agency for Healthcare Research and Quality, 2009). Among those with serious mental illnesses, adults aged over 50 were more likely to use mental health services (71%) than adults aged 18–25 (40%) (Substance Abuse and Mental Health Services Administration, 2009).

A variety of social, financial and systemic barriers contribute to the lack of psychiatric treatment. Although society's perception of individuals with mental illness has improved, stigma is still significant. A negative attitude to mental illness, which can be expressed as distrust, stereotyping, fear, embarrassment, anger and avoidance, often inhibits people from seeking treatment.

Service delivery

A range of services and treatments to help people with mental disorders is provided by a variety of caregivers working in public and private settings. There are four major components to these services:

- specialty mental health professionals (psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, etc.)
- general medical practitioners
- social services providers (e.g. school-based counselling, vocational rehabilitation)
- informal volunteers (e.g. self-help groups).

Approximately 15% of adults and 21% of children and adolescents in the USA use these services each year (Surgeon General, 2001). Most care is provided in out-patient settings (public or private clinics or offices). Acute hospital care is usually provided in psychiatric units of general hospitals rather than in free-standing psychiatric hospitals.

Patients frequently seek care exclusively from primary care physicians and clinicians. For example, more than 50% of patients with depression see only primary care physicians or clinicians (Kessler *et al*, 2003).

The roles of consumer self-help, consumer-operated, consumer advocacy, family support and peer support services are expanding. There are also increasing efforts to coordinate not only medical and mental health services, but also other services for those recovering from mental illness, such as education, housing and employment. However, these are generally fragmented and dispersed among a number of organisations, both private and government-based.

A history of deinstitutionalisation

In 1955 there was one psychiatric bed for every 300 Americans; today there is one for every 3000 (Torrey *et al*, 2010). Beginning in the mid-20th century, large psychiatric hospitals began to close so that care could be provided to patients in less isolated, more inclusive community mental health services – a process referred to as deinstitutionalisation. Although this was successful for some people, community resources have not been available or have been inadequate for many others. People with mental disorders have all too often ended up homeless or as inmates in the criminal justice system.

New laws providing greater access and coverage

Recently enacted laws are expected to go a long way to improve access to care for those with mental illness. The 2010 Patient Protection and Affordable Care Act will have far-reaching effects on patients, as well as on psychiatrists and other physicians. It will provide comprehensive health insurance coverage, including for the treatment of mental illness and substance misuse, to an estimated 30 million Americans who are currently uninsured.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 specifically expands federal requirements for mental health coverage. Private insurers who cover mental health must provide coverage at least equivalent to that for other medical illnesses. Furthermore, co-payments for mental health services cannot exceed those for general health services, and insurers may not impose special limitations on the number of mental healthcare visits.

Workforce and resources

There are more than 40 000 psychiatrists in the USA. Approximately 137 psychiatry residency programmes accredited by the Accreditation Council of Graduate Medical Education (ACGME) train some 6000 residents each year. There are nearly 9000 advanced practice psychiatric nurses who provide mental health services, including prescribing (under varying state regulations), and more than 90 000 psychologists who provide services, generally not including prescribing.

Clinicians providing mental health services do not reflect the ethnic diversity of the US population. Members of the major ethnic/racial minorities in the USA make up about 33% of the population, but only about 25% of physicians, 19% of psychiatrists, 10% of psychologists and 15% of social workers. There is even greater disparity among specific racial/ethnic groups. For example, African Americans make up approximately 13% of the population, but only 3% of psychiatrists and 2% of psychologists, and Latinos make up about 14% of the population but only 5% of psychiatrists and 3% of psychologists (Sribney *et al*, 2010).

More resources are available in some parts of the country than in others. There are over 3500 'health professional shortage areas' for mental health in the USA, affecting more than 84 million people, 65% of them in non-metropolitan

areas. Although the total number of psychiatrists per 100 000 population has been relatively stable over the past 20 years, the average age of psychiatrists (half are over 55) has raised concerns that there will soon be too few to meet future demands (Skully & Wilk, 2003).

Key factors in the future are likely to include the changing scope of practice and roles of non-psychiatrists; growth and ageing of the population; mainstreaming of psychotropic drugs; increasing insurance coverage; and changing utilisation patterns in subpopulations (e.g. Latinos) (Vernon *et al*, 2009).

Financing mental healthcare

In terms of healthcare expenditure, mental disorders are among the five most costly types of health conditions in the USA (along with cancer, heart disease, asthma and trauma-related disorders) (Agency for Healthcare Research and Quality, 2009). Mental healthcare in the USA is paid for from a combination of public and private sources, including public funding (Medicaid, 18%; Medicare, 22%), private insurance (28%) and out-of-pocket individual/self-pay (25%) (Agency for Healthcare Research and Quality, 2006).

Other sources of federal funding include the Veterans Administration and Department of Defense (through service delivery), the Substance Abuse and Mental Health Services Administration (through block and discretionary grants), and the Health Resources and Service Administration (via federal community health centres).

States have traditionally served as the safety net for people unable to access mental health services and have carried much of the responsibility for low-income individuals with serious mental illness. The recent economic downturn has forced many states to scale back this funding.

Critical issues

Several critical issues currently affect mental healthcare and will continue to do so in the near future. Access to care is limited by problems in rural areas (travel distance for patients, a scarcity of providers) and also by stigma and too few culturally competent and linguistically diverse providers. Another challenge is the lack of coordination of care – of public and private services, of various specialty services, of general medical and mental health services, and of social services and other institutions (housing, criminal justice, education). Also at issue is growing public concern over the influence of pharmaceutical companies on how physicians practise. The transition to the use of electronic health records is another major adjustment.

Although psychiatry remains an important and fulfilling career in the USA, there will be many challenges for patients and mental healthcare workers for many years to come. However, there will also be many new opportunities to provide better mental health services for all those who need them.

References

Agency for Healthcare Research and Quality (2006) *Medical Expenditure Panel Survey* (Table 4: Total Expenses and Percent Distribution for Selected Conditions by Source of Payment: United States, 2006). AHRQ.

Agency for Healthcare Research and Quality (2009) *The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Non-institutionalized Population*. Statistical Brief No. 248. AHRQ. Available at http://www.meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf (accessed July 2010).

Kessler, R. C., Berglund, P., Demler, O., *et al* (2003) The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA*, **289**, 3095–3105.

Kessler, R. C., Demler, O., Frank, R. G., *et al* (2005) Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine*, **352**, 2515–2523.

National Institute of Mental Health (2010) *The Numbers Count: Mental Disorders in America*. NIMH. Available at http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml (accessed July 2010).

Skowyra, K. R. & Cocozza, J. J. (2006) *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*. National Center for Mental Health and Juvenile Justice, Policy Research Associates, Inc. Available at http://www.ncmhjj.com/Blueprint/pdfs/Blueprint.pdf (accessed July 2010).

Skully, J. H. & Wilk, J. E. (2003) Selected characteristics and data of psychiatrists in the United States, 2001–2002. *Academic Psychiatry*, **27**, 247–251.

Sribney, W., Elliott, K., Aguilar-Gaxiola, S., *et al* (2010) The role of non-medical human services and alternative medicine. In *Disparities in Psychiatric Care* (eds P. Ruiz & A. Primm), pp. 274–289. Lippincott, Williams & Wilkins.

Steadman, H. J., Osher, F. C., Robbins, P. C., *et al* (2009) Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, **60**, 761–765.

Substance Abuse and Mental Health Services Administration (2009) *National Survey on Drug Use and Health, 2008*. SAMHSA. Available at http://www.oas.samhsa.gov/NSDUHlatest.htm (accessed July 2010).

Surgeon General (2001) *Mental Health: Culture, Race, and Ethnicity*. US Department of Health and Human Services. Available at http://www.surgeongeneral.gov/library/mentalhealth/cre/ (accessed July 2010).

Torrey, E. F., Kennard, A. D., Eslinger, D., *et al* (2010) *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*. Treatment Advocacy Center (TAC) and National Sheriffs Association (NSA). Available at http://www.treatmentadvocacycenter.org/storage/tac/documents/final_jails_v_hospitals_study.pdf (accessed July 2010).

Vernon, D. J., Salsberg, E., Erikson, C., *et al* (2009) Planning the future mental health workforce: with progress on coverage, what role will psychiatrists play? *Academic Psychiatry*, **33**, 187–192.

World Health Organization (2009) *World Health Statistics 2009*. WHO. Available at http://www.who.int/whosis/whostat/2009/en/index.html (accessed July 2010).

Bursary from the Faculty of the Psychiatry of Old Age

The Faculty has established an annual bursary to enable a psychiatrist from a low- or middle-income country to attend its annual residential meeting (the next will be 17–18 March 2011, in Stratford-upon-Avon) in order to give an oral or poster presentation, or deliver a workshop. The bursary is intended to cover the cost of economy-class travel, accommodation, free registration and attendance at the conference dinner, up to a maximum of £1500. Informal mentors will be identified for the bursary-holder. For details of regulations please visit the Faculty website at http://www.rcpsych.ac.uk/specialties/faculties/oldage.aspx. The closing date this year is 31 October 2010 and submissions should be sent to the Faculty Academic Secretary (email kkottasz@rcpsych.ac.uk).