Towards a More Comprehensive Treatment Approach to Mental Disorders:
Argentina and the United States

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While Latin America and the United States are separated by geography, language and culture, surprising similarities are in evidence as these countries have moved toward deinstitutionalizing their psychiatric populations. Both countries struggle with serious gaps in service that are leaving patients unable to construct their own lives after being discharged from their “so-called” therapeutic environments (Mechanic, McAlpine, & Olfson, 1998; MDRI & CELS, 2007). While treatment strategies vary within and between countries, extended and often costly treatment in both countries do not lead to improved patient health. The comparison outlined in the paper is especially relevant because Argentina is presently undergoing the process of deinstitutionalization as an attempt to make mental health a higher priority. Because The United States underwent that process beginning in the 60s, it provides insight into problems and challenges that can arise from transforming the mental health system away from institution-based care (Smucker, 2007). The cross-cultural comparison is quite relevant today because Argentina is attempting to make mental health a higher priority, yet outcome studies in the United States indicate that deinstitutionalization has not materially succeeded in improving the overall well-being of the patient.

This paper highlights the differences between the two systems in their approaches to mental health care and identifies parallel shortcomings both countries fail to overcome. The conclusion suggests strategies useful for both countries to address some of these complexities. In this thesis I will be discussing the role that government decisions, public facilities, and home environments have as barriers to the partner’s movement towards well-being. To understand the extent of which partners are affected by the present mental health treatment system and the

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1 The term “patient” will be used when discussing individuals with mental illnesses who have no perceivable control over their treatment. “Partner” refers to individuals with mental illnesses who are active participants in designing their treatment.
way to create the most cohesive and effective care system, it is essential to consider the family situation and construct treatment approaches which more fully utilizing community resources.

In order to discuss treatment for this population, it is necessary to first understand the affected population: what are the symptoms and difficulties attached to having a mental disorder, what are the patterns of co-morbidity with drug or alcohol addiction, does this population struggle with homelessness, and how are they affected by laws and policies, and their home environment (Epstein, Barker, Vorburger, Murtha, 2002). This paper posits that the people struggling with these problems are seriously restrained in their recovery process due to the lack of a cohesive approach to these challenges.

Of the disorders that are most often seen to pose the greatest difficulties to clinics are bipolar disorder, schizophrenia, and major depressive disorder² (Garay & Korman, 2008; Gianfrancisco, Wang & Yu, 2005). To understand the difficulties of having one of these challenging disorders, it is necessary to have a better understanding of the symptoms and the effects they have on the individual experiencing them and also on the family. It is important to note that length, severity of each different episode, and remission period varies person by person.

*Bipolar disorder*

Bipolar disorder is characterized by mood swings that move from mania to depression (Miklowitz, 2008). Mania can be described as a period when someone is overly euphoric or

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²All of these disorders vary substantially from case to case in symptomatology and emergence. Each of these disorders has been seen in children, however it more commonly emerges in early adulthood (early-mid twenties). This is not to say that people who are diagnosed in their adulthood do not show behavior that is perceived to be disturbing or strange by family members or others in the community. With the emergence of these illnesses in individuals, key educational and social development is severely interrupted usually seriously affect long-term cognitive functioning.
irritable, experiencing rapidly changing moods, have fast-paced thoughts and speech, decreased inhibitions, paranoid or grandiose delusions, and significant increased activity of spending, drug, or alcohol intake. During times of depression these individuals feel hopeless and worthless, unable to experience pleasure, have a preoccupation with death, and exhaustion (Torrey & Knable 2002). Presently the standard approach to treating bipolar disorders includes monitoring patient health in an inpatient ward, providing them with medication and limited therapy, stabilizing the patient and depending on the response to the medication, discharge (Nivoli, Murru et al., 2012).

Schizophrenia

Schizophrenia, considered one of the more mysterious and debilitating disorders, presents very different symptoms (Van Os & Kapur, 2009). Symptoms can range from the emergence of new cognitions such as delusions and hallucinations, the disappearance of cognitions such as emotional or social withdrawal, incompassible thought and speech, and affective flattening, or symptoms can be more of an erratic behavior such as having inappropriate affect or behavior considering the context (Picchioni & Murray, 2007).

Usually this will require hospitalization because few families or communities know how to respond to such a drastic change in behavior (Marsh & Lefley, 2003). Hospital stays generally last between a few days to a week during this acute phase. During the acute phase the treatment procedure is to first confirm the initial diagnosis of schizophrenia and then to move towards stabilization through antipsychotic drugs (Bellack, Buchanan, & Gold, 2001). Following discharge, the patients are often directed to outpatient services to continue receiving medication and also for psychosocial support, such as group therapy and behavioral therapy (Bellack, Buchanan, & Gold 2001).
Major Depressive Disorder (MDD)

Major depressive disorder (MDD) is characterized by a person becoming sad or irritable, often without an external cause or after the external cause of the emotions is no longer actively disturbing. This mood change is accompanied by a combination of unusual patterns of eating, sleeping, or sexual desire, inability to experience pleasure, crying, or suicidal ideation (Belmaker & Agam, 2008).

Once a patient either feels unable to take care of their lives themselves (and there is no family support) or they threaten or attempt to commit suicide, they will then be entered into an inpatient hospital or clinic. There they will be prescribed antidepressants or electroconvulsive therapy to get help in the stabilization process (Berton & Nestler, 2006). Usually patients see improvement in their disorder in 4-12 weeks, with the medication taking a few weeks to begin to have a noticeable effect (Berton & Nestler, 2006; Bschor & Adli 2008). While undergoing ECT and medication trials, acute therapy also is a key part of helping patients work through their depression and finding ways of coping with their depression. Once the acute phase of the episode has stabilized, then the patient’s continuation with outpatient medication and maintenance therapy is essential for preventing relapsing into another depressive episode (Richards, 2011). This outpatient therapy aids the patient’s transition back to pre-morbid levels of functioning at home and work (Bschor & Adli 2008; Leiderman, Lolich, Vázquez, & Baldessarini, 2012).

However there is more to understanding the experiences that patients undergo when being treated than just identifying their symptoms. Patients may also be struggling with problems of drug and alcohol addiction, financial difficulties, homelessness, limited social support, and loss of control over their own lives. Each of these problems causes more barriers
to patients’ ability able to work with their disorder and not feel so incapacitated by their difficulties.

Additional difficulties are present in this population due to drug and alcohol co-morbidity that often comes hand in hand with a severe mental illness (Epstein, Barker, Vorburger, Murtha, 2002; Drake, O’Neal, & Wallach, 2008; Inchaurreaga, 2003; Richter, 1998; Sun, 2012). When there are substance abuse problems on top of their mental disorder, there are additional barriers to medication management, financial planning, and self-care. Not only are they unable to effectively care for themselves, but if they are living in a half-way house or in their family homes, there are very few living situations tolerant to a substance-dependent individual because substance abuse makes it very difficult to motivate to work towards treatment (Folsom et al., 2005).

To add to these pressures, in low-income families there is extra stress on the family because they are financially restricted in their access to mental health services (Clark et al., 1994; Dupère & Perkins, 2007; Gianfrancesco, Wang, Yu, 2005). This puts further pressure on the family to either handle all care for their ill family member themselves or put them in state funded inpatient hospitals. Often however, they are unable or disinterested in taking over the care of their ill family members, thereby leaving the patients to live on the streets. When they are homeless, they are extremely vulnerable to very traumatic experiences and violence that augments the stressors in their life.

After the emergence of a severe mental illness, partners are faced with a changing world where they are considered incapable of competent thought and thereby told what to do, when to do it, and how to do it, or they are given no instruction at all (Lefley 1997). Without that structure, it is difficult to control their lives and organize all the responsibilities they have,
whether it is filling out the proper paperwork for social security disability income (described later in this paper) or taking proper care of themselves (bathing, sleeping consistently, eating, etc.). But with that structure, they never learn how to be autonomous and work within the limitations of their disorder. In either situation, within their family, they become a burden because of the dependant nature that is often fostered by treatment facilities and families. This can create complex negative relationships within the household and destroy the social support bond that the family could provide in an ideal situation. Additionally, due to their often-erratic behavior, patients are unable to sustain friendships or receive substantial social support (Kohn-Wood & Wilson, 2005). Therefore patients are left to deal with their situation often alone.

As seen in this portrait of the population, because of the combination of difficulties that they are dealing with (mental illness, often addicted to drugs or alcohol, have limited resources, and are transitioning into adulthood and independence) and because of deinstitutionalization in both Argentina and the United States, they become the responsibility of their family. Once the family member is let out of an inpatient facility, they are rarely given long-term or community-based treatments (Rosenheck, Kasprow, Frisman, Liu-Mares, 2003). They are advised to go to the outpatient services that were associated with the hospital they were in previously, but there is usually very limited follow-up with the patients beyond that suggestion. This essentially provides the patient with two options: return to their family (if that is an option) or live on the streets (Folsom et al., 2005).

Ultimately, the problem is that this population of severely affected mental health partners is not being helped by the current poorly-equipped system and so they most often are left without long-term support. Furthermore, even if the family is the main caretaker, they are given little to no training or support in dealing with these problems. With limited therapeutic
support, it is almost a certainty that the patient will return to an inpatient hospital, jail, or rehabilitation in a short amount of time following release (Wang et al., 2005).

In order to illustrate this picture, I will be outlining Argentina and the United State’s policies, the facilities that should be carrying out these policies, and the highly visible limitations of this system. Once the present mental health system is depicted, options of how to approach meeting the needs of the caretakers and partners in this process will be offered as holistic alternatives to better serve these individuals. Ultimately this paper strives to show how the present approach to mental health treatment disturbs partners’ ability to establish their own lives and gain autonomy from their treatment process and suggest alternatives that can address these goals and facilitate the education and inclusion of all affected actors.

Argentina

In Argentina, despite the new policies and legislation that are trying to redirect mental health services towards deinstitutionalization, institutionalization is still very much active today (MDRI & CELS, 2007). This is in part because the patients have no other place to go, particularly if they are homeless or live in the “villas,” the ghettos in the outskirts of the city.

However, because the therapy and medication prescriptions are designed for patients who will stay in the hospital for an extended period of time, the treatments are directed toward stabilizing the mentally ill patient with drugs rather than on preparing them to return to their communities (Moldavsky, Savage, Stein, Blake, 2011). Once they leave the clinic, they are unprepared to deal with their daily interactions. Combine these poor preparations for the world outside of the institutions with very limited follow-up treatment from the hospital and limited

3 This paper focuses on the city of Buenos Aires, the capital of Argentina, an urban, well- resourced city, but this is not to say that the rest of the country has these same services. Services are allocated province by province, therefore provinces that are not well funded do not receive adequate mental health services (Moldavsky, Savage, Stein, Blake 2011; WHO 2011).
communication between different service providers about the incoming partners, and this creates a constant pattern of people being brought back to the government facilities shortly after being released. Services outside of the wealthier areas of Buenos Aires have even more limited services, presenting an even bleaker picture for the patients there (Moldavsky, Savage, Stein, Blake, 2011; WHO, 2011, WHO, 2005).

**California**

California’s mental health system also perpetuates the stagnation of its partners by not providing ways to transition from being hospitalized to being back to their communities (Wang et al., 2005). However California does not face the same kinds of problems that are present in Buenos Aires. While Argentina is presently trying to move towards deinstitutionalization, California went through that phase of their mental health system in the 1970s and 80s (Benson, 1994). Both then and now, the mental health patients who rely on the state for their services remain the same: often homeless, struggling with substance abuse, estranged from their family and friends, with their illness not radically improving over time. The hope was that the end of institutionalization would allow for more personalized treatments and for communities to find ways for these members of their community to join in a healthy and holistic manner. However, this has yet to become a reality.

Instead what presently exists is a pattern where patients cycle through different government programs such as the prisons, rehabilitation clinics, or emergency psychiatric services in hospitals (Wang et al., 2005; Grant et al., 2011). Because there are not long-term institutions, patients are brought to these services for short-periods of time where they are stabilized through medication for no more than a week and then they are dismissed back into their communities without any substantial follow-up procedures. These state facilities are
overcrowded and understaffed so that although medication is usually regularly provided (in quite high dosage to keep the patients subdued) additional services are not provided in a manner that adapts to the individual needs of a patient or helps them to move towards not depending on these short-term holding cells that they are rotated through (Gold Award, 2001). A major problem with this system is that it not only encourages people to remain dependent on the system, but it also does little to get them out of negative environments (homelessness, living situations with heavy drug use, or prostitution). Therefore their care ends up being thrust on either their families or alone without being able to stop the cycling. Because families are not trained and are not usually welcome to join in the treatment process of their loved one, when the family member is returned to their household, there are very limited steps that they can take to be of help (Gold-berg-Anold, Fristad, Gavazzi, 1999). In rural environments, this is even truer (Kohn-Wood & Wilson, 2005; MRHRC, 2010).

Essentially what we see in both Buenos Aires and California, is a stagnation of healing when it comes to treating mental health disorders either due to a hold-cell type of treatment approach or due to a short-term cycling system that forces system dependency on the patients. Because mental health treatment in Argentina and the United States often takes partners outside of their environment, provides them with stabilizing treatment, and then discharges them back to where they were before (home, halfway house, or the streets), when they are placed back in their environment, the family is unsure of what condition their loved ones are in (Lefley, 1997). Ultimately the problems that emerge from these systems are the same: patients and their family members are lost once there is not this state facility to take care of the patient when their symptoms are exacerbated. But to create significant change in the system, there would have to be far more community involvement and that is something that many non-afflicted members of
the community are not interested in. Until the community and family unit is recognized as an agents of change and knowledge and a group who also needs support from services when treating an ill family member, progress will continue to be very limited.

**Policy, Legislation, and Financing**

Many actors influence how the mental health system is organized, but the government has played a particularly important role in creating policy, legislation, and financing that structures what partners can receive for treatments. For the purposes of this paper, policies are defined as ideal desires of what health care should cover and provide treatment for, legislation are the laws that are enforced (to varying degrees), and the financing refers to the national laws that dictate what kind of support people with disabilities are eligible. Argentina is a unique situation due to it’s public health care and only recent progression towards developing policies and laws regarding mental health advocacy. In the United States, a country with extensive government legislation that mandates what can be designated as appropriate action or not, there are an abundance of rules that overlap and add to the complexity of receiving integrated treatment.

**Argentina**

Throughout the 20th century, Argentina experienced a series of dictatorships, which brought on a very extended period repression. However, throughout this time and particularly in the late 1950s there was a movement towards more therapeutic and creative approaches toward mental health care and treatment. During several regime changes between the 50s and 70s, mental health reformers continued to work on significant reforms affecting family abandonment, the ineffectiveness of large asylums, the development of psychiatric clinics in
general hospitals, and overall alternative treatment practices focusing on rehabilitation and social regeneration instead of on confinement and segregation (Albard 2008).

Then in the 1970s, political instability, in addition to the quick succession of several regimes, brought on a period of horrific terror led by the government against any suspected revolutionaries. As psychologists and psychiatrists made up a large part of the liberally minded population the government feared they were frequently fired or disappeared, thereby creating a tremendous loss of employees and leaders in the psychological world in Argentina. To take the place of these reform-minded mental health workers were many of the previous guards and psychiatrists whose focus was on containment of people with mental health disorders, instead of trying to bring them back into the community. In total during these six years of terror and repression, the government is thought to have killed up to thirty thousand people, with an estimate of thirteen thousand bodies still missing (Albard 2008; Garcia, Rodriguez, Koslow, 1989; Moldavsky, Savage, Stein, Blake, 2011; MDRI & CELS, 2007).

Now, there is a generation of professionals missing and although there is a vibrant culture of mental health care and treatment, Argentina has yet to recover completely. It is still working to emerge from this period of repression and create legislation for mental health care. Much of the legislation that has been developed thus far has not improved the lives of its citizens because of not having the infrastructure or sufficient resources to implement the laws (Albard 2008; Ceriani, Obiols, Michaelewicz, 2009).

Policies

With a history tainted with so many human right violations, Argentina has worked hard to create laws that promote justice and equality across all dimensions of the society. As a result of this effort, Argentina has created policies that, although following internationally promoted
ideas for creating a holistic and ideal society, they are very difficult to enforce (Ceriani, Obiols, Michaelewicz, 2009; Moldavsky, Savage, Stein, Blake, 2011). In addition, most of the mental health legislation has been very recent. This is most likely due to their history of having a repressive government for so many years and now the population has a general distrust of any government legislation that tries to take too firm of a hand in their lives.

Presently, Argentina has a mental health policy, which was initially formulated in 1957 and then revised in 2001 with input from politicians, mental health professionals, NGOs, and public servants. This policy touches on mental health ideals for the nation. The three component of the policy are:

1. Education and promotion of treatment approaches for mental health issues (community and professional education and promotion for the understanding and treatment of mental health issues)

2. Country-wide prevention and treatment programs

3. Rehabilitation programs for mental health and drug and alcohol treatment

Regular funds for implementation for these three components were allocated, but not at the funding level required. As Argentina has a federal governance structure, different regional mental health programs and approaches are in place in each of the different provinces. Presently there is no overall enforcement or planning system in place. Professional working groups are currently attempting to standardize standards and approaches of treatment across the provinces (WHO 2005).

In 2001 the Programa de Asistencia Primaria en Salud Mental ley 25.421 (Program for Mental Health Services in Primary Care, Law 25.421) was passed, establishing that everyone who enters the country has the right to free mental health care, included in primary care
services. It also states that these primary care services provide for the rehabilitation and social reinsertion of persons with mental illnesses. However, as stated previously, for these types of policies, there is little enforcement or follow-through on these laws, so the majority of public psychological care is based primarily on institutional care (CELS 2007).

**Legislation**

For national legislation on mental health, there is only one newly created law presently in place: The *Ley National de Salud Mental, ley 26.657* (National Mental Health Law #26.657) (2010). This law first restates the dedication to protecting mental health rights for all Argentine residence, following UN guidelines. When they outline the appropriate approach modalities they state that treatment should include an interdisciplinary team (technicians, workers trained in mental health care, etc…), should take place beyond the limits of one’s hospitalization stay, and that when prescribing medicine it must only be for therapeutic purposes, not for punishment. As for hospitalizations, it demands that they only be for therapeutic aid for the partner, lasting for as little time as is possible, with the staff completing evaluation, diagnosis, and developing reasons justifying hospitalization (signed by at least two professions in the hospital—one being a psychologist or psychiatrist) by the end of the first forty-eight hours of hospitalization. It also demands that 10% of the overall health budget of the country goes to mental health services (Moldavsky et al., 2011). These policies have yet to be even partially implemented.

**Financing**

The budget for mental health services varies significantly by provinces by 0.5%-5% of that provinces health budget. Nationally, 68% of the mental health budget goes to psychiatric hospitals, leaving community mental health resources under-financed.
At a national level, the primary sources for mental health financing in descending order are taxed-based public funding, obras sociales (union-based social insurance), private insurance companies, out-of-pocket expenditures by the family (WHO, 2005). Each province has a public health policy that provides for free coverage for specified mental health services. However it’s resources are quite limited, particularly in rural areas. Local councils and provincial governments provide the funding for large psychiatric hospitals. However, these are not well financed and in the rural communities, workers are often undertrained and/or work voluntarily. “Argentina has a total of 20,945 beds with half being public sector financed and half being privately financed” (WHO, 2005).

Argentina has a very unique health care system in comparison to the United States. There is complete national public coverage of health care services—their motto is that that health care is a universal right regardless of nationality, socioeconomic status, or income. As soon as a person enters the country, they are eligible to receive medical care, including mental health services. This health care system is made up of three mechanisms to cover a variety of services: the public sector funded by the government through taxes, private sector financed through voluntary insurance, out of pocket payments and obras sociales where worker’s unions will provide health and mental health care insurance for each employee and their immediate family (IRBC, 2001; Belmartino, 2000; WHO, 2005).

**Buenos Aires**

**Policies**

Due to the limited number of policies at the national level, each province is left to create their own policies and legislation and try to enforce those based on the resources they have. This creates a wide diversity of resources across the different provinces. The province of
Buenos Aires, being where the capital is also held, has particularly strong funding and is able to provide more resources to people. However, this does not mean that the policies that exist are enforced any more regularly than the national policies. They remain equally difficult to achieve due to the lofty missions of these policies, legislation, and lack of financial support.

There are two primary policies in place in the province of Buenos Aires: the 1996 Basic Health Law No. 153 and the Mental Health Law of the city of Buenos Aires, No. 448, passed in 2000. The Basic Health Law, among statutes directed toward other health problems, requires city governments to enforce progressive deinstitutionalization and calls for a focus on social integration when treating mental health disorders. In 2000, the Mental Health Law was passed as a way of restating many of the same goals of the Basic Health Law, but in a law specifically directed toward mental health goals instead of only general health care. In this law mental health care is guaranteed as a right of all residents in the city of Buenos Aires. It additionally calls for deinstitutionalization and for the people who are presently institutionalized it is demanded that they receive rehabilitation and social reinsertion in place of hospitalization. It also puts forth that the Buenos Aires mental health system will be based on prevention, promotion, and protection of mental health and those affected by mental health problems, particularly through eliminating asylum-based treatment and moving toward community mental health services instead. But it does not mention any review of detentions by any kind of impartial review body, protecting against arbitrary detentions (Ceriani, Obiols, Michaelewicz, 2009; Moldavsky, Savage, Stein, Blake, 2011; WHO, 2005).

Legislation

No provincial laws beyond those at the federal level.

Financing
It is the same system as at the federal level.

**United States**

*Policy*

In 2003, the “new freedom commission on mental health” that, at the request of the president, issued a report entitled, “achieving the promise: transforming mental health care in America”. In 2004, the US Center for Mental Health began working with the states to implement the six goals of this report. These goals included:

1. Early detection of mental illness,

2. Universal coverage of mental illness with access to effective treatment and support,

3. Acceleration of the use of technology to help access mental health care and information,

4. Eliminate the geographical and social status disparity in access to mental health services,

5. Increased focus on research and evaluation of mental health services,

6. Improved epidemiological and demographic research on frequency and causation of different forms of severe mental health issues (ex/: why poor areas have so much more of specific types of disorder)

(WHO, 2005: America)

*Legislation*

A series of national mental health legislation in the past decade and a half have focused on funding programs for children and adolescent mental health, increasing parity between mental health and health care benefits, confidentiality of partner records and claims processing, and mandated psychiatric treatment throughout the criminal justice system.

Ex/:  
The Public Health Service Act (1944):
The Health Insurance Portability and Accountability Act (1996)
Mental Health Parity Act (1996)—updated in 2005
The Children’s Health Act (2000)
(WHO, 2005: America)

Financing

At the national level, there are a series of methods of providing funding for health services: Medicaid, Medicare, Supplemental Security Income, and social security disability income. There is also private insurance if you can afford that, but most of the population that this paper is focusing on will not be able to purchase private insurance.

Medicaid is a health and long-term care coverage program set up for low-income individuals and families, people with disabilities. States and federal government jointly finance this program with each state establishing and administering their own Medicaid program. This includes type, amount, duration, and range of services, which are loosely outlined by federal guidelines. These services range from doctor visits, emergency care, hospital care, prescription drugs, vision, hearing, and long-term care (CMS, 2012).

Medicare, often confused with Medicaid, is a social insurance program that is exclusively funded by the federal government. It provides people 65 or older, people under 65 if they have disabilities, and people with end stage renal disease with coverage for their hospital bills, medical insurance coverage, and prescription drugs (CMS, 2012).

Supplemental Security Income (SSI) is another governmental program that helps low-income people receive stipends that help meet the their basic needs for food, clothing, and shelter. This is provided to people over 65 years of age, blind, or disabled and live in the United States. Resources can only be provided in cases where people have limited income
The final source of federal funding is the Social Security Disability Income, which is only for disabled or blind individuals who require income supplements because of a notable disability. Depending on the duration of the disability, SSDI can be supplied on either a temporary or permanent basis. Additionally income of the disabled individual is not relevant to whether or not they receive services. But what is relevant is if they are able to perform a substantial gainful activity, able to perform any work in the economy, and if it is severe (SSO, 2012).

The primary sources for US mental health financing are in descending order: private insurance, federal and state tax-based programs, out-of-pocket expenditures by the partner. In 2005, the United States spent 6% of the total health care budget on mental health programs and services. While the United States does not yet have a universal health insurance program (depending on the upcoming election), about 17% of the population is without any form of insurance. Federal programs such as Medicaid and Social Security Disability Insurance have increasingly been funding coverage for those with the most severe mental health issues. The Federal Supplemental Security Income (SSI) for severely disabled low-income populations and Social Security Disability Insurance (SSDI) for workers and family members who are experiencing severe mental health problems. Eligibility for these two programs result in coverage by Medicaid or Medicare for certain types of mental health problems (WHO, 2005: America).

California
Policy

No others besides federal level.

Legislation

The legislation in California has been built upon the legislation of the United States to act as a specialized group of laws to create a health care that responds to the direct needs and ideals of the population living there. The passing of the Mental Health Services Act (2004) suggests that California’s politicians are making mental health care an emerging priority. The Mental Health Services Act was set up to increase the mental health services available by placing an additional one percent tax on individual taxable income that exceeds one million dollars (WHO, 2005).

Prior to the Mental Health Services Act, there was a series of other mental health care legislation which was passed which also provided more structure to the way community members can have more say in mental health care. In 2002, Laura’s Law, which permits courts to order someone to enter into assisted outpatient treatment and or take antipsychotics in cases where the individual is showing obvious signs of not being able to care for themselves, are in declining condition, are not yet either at risk of harming themselves or others but could turn towards that, and have not followed up or not complied with treatment (NAMI, 2010).

There have also been a several sections of the California Welfare and Institutions Code that were developed regarding involuntary commitment: section 5150, 5120, and 5270 (CWIC). Section 5150 describes when someone can be involuntarily confined to an inpatient hospital by a clinician or officer for up to 72- hours against their will. This is only acceptable if the patient is a danger to themselves or other, or gravely disabled to the point where they cannot care for themselves. During this time, they will be assessed and diagnoses to make sure they do qualify
for hospitalization. If they do, then they are offered voluntary admission to the hospital, and if they refuse, it will take a second form, the 5250, to hold the person for another 14 days without their permission. To continue the involuntary hold for any longer, it is necessary to have a 5270 hold written which leads to an additional thirty day involuntary psychiatric hold on top of the 72-hour and 14 day hold (Bruckner, Yoon, Brown, & Adams. (2010).

Financing

As described above, Medicaid is a program that coordinates federal and state funding for health care within a state. In California, Medicaid is administered through its own program named Medi-Cal, which decides what health programs and services need to be available to the public. Medi-Cal is eligible to the same people as Medicaid: persons 65 or older, persons under 21 years of age, adults between 21-65 if they have children under 21 who require support, disabled persons, certain refugees, and pregnant women. Medi-cal is the name for the way in which the state of California interpret the policies constructed for Medicaid and the way the state funds half of the costs of medical care for the population named above. Medicare, social security disability income, and supplemental security income all remain to be key features of financing at the state level. Each of these funding mechanisms have very little appropriation for community-based services. The funding is largely focused on hospital and licensed practitioner treatment (HPC, 2012).

State mental health programs and services have been developed to augment gaps in the federal programs. However, as budget cuts over the last five years have mounted, state funding for both inpatient and community services for children and adults with serious mental illnesses have been significantly downsized or eliminated. In California, “which has cut over $750 million of its mental health budget in recent years, the governor has suspended mandates on
counts to provide mental health services to special education students, meaning that the burden of providing and paying for their care has been shifted to the school systems, which are also struggling with limited resources” (Disability Rights California, 2010). These cuts at the state level, in combination with a lack of funding for even mandated programs at the federal level, have caused individuals experiencing severe mental health issues to use emergency rooms and hospital based treatment rather than a more systematic and community based programs.

**Facilities**

*Buenos Aires Facilities*

Argentina has a very unique health care system in comparison to the United States. There is complete national public coverage of health care services—their motto is that health care is a universal right regardless of nationality, socioeconomic status, or income. As soon as a person enters the country, they are eligible to receive medical care, including mental health services. This health care system is made up of three sections to cover a variety of services: the public sector funded by the government through taxes, private sector financed through voluntary insurance, out of pocket payments and obras sociales where worker’s unions will provide health care insurance for each employee and their immediate family (Immigration and Refugee Board of Canada 2001; Belmartino 2000; WHO 2005).

Under this system there are a wide variety of facilities and services provided, but for the purposes of this paper, I will only be focusing on the facilities and services that low-income mental health patients are usually directed to. The facilities used are in-patient hospitals either used exclusively for mental health care or with a specific ward for mental health services and outpatient hospital or clinic services. The three primary inpatient hospitals are the Jose Tibucio
Borda Interdisciplinary Psychiatric Hospital, a hospital only for men, the Braulio A. Moyano Psychiatric Hospital, which only serves women with mental illnesses, the Dr. Carolina Tobar Garcia Children’s Hospital, and the half-way house Psycopathologic Center Aranguren. Within these in-patient hospitals, there is often a segregated ward that holds inmates who have been transferred from a prison setting to the mental hospital if their crime was deemed to be influenced by their mental disorder. There are no psychiatric beds in prison for inmates with mental disorders (WHO 2005).

The in-patient hospitals provide medication, therapy, beds, food, and depending on the hospital, there can be activities such as a radio groups, classes to get a degree, or performances of bands or plays. The delegation of services for each patient depends on their symptoms, but for situations where people are primarily in the hospitals for an unlimited time due to them not having a place to move to, they will often not be receiving any services besides food and shelter (MDRI & CELS 2007). In the outpatient hospital and clinic services, patients are provided with medication, day treatment programs, group therapy, a specified amount of therapy, and occasionally support through job searches (MDRI & CELS 2007).

Across Argentina there are 225 facilities that have psychiatric beds (half in public psychiatric institutions, half in public institutions); about 6 psychiatric beds in hospitals across the country per 10,000 people, however this statistic demonstrates how these facilities and resources are organized to be almost exclusively in highly concentrated areas (WHO 2005). Of these psychiatric beds in Argentina 80% are occupied by patients staying for more than a year, 15% for stays between three months to a year, and 5% are for staying lasting under three months (WHO 2005).
For populations that are located on the outskirts of the city, generally the poor immigrant or indigenous populations, getting to hospitals located in the city can be very difficult and unaffordable. Therefore, mini-clinics have emerged called “salas”. There is very limited treatment and services, but because it is such an ignored population who lives there, few politicians try to improve their resources.

Recently, there has also been the emergence of halfway houses where patients are being delegated to after they are stabilized and are capable of living, at least in part, independently. In these halfway homes, the patients are provided with group therapy, food, and social company. Within this environment, patient’s have more autonomy to find ways to engage with their communities and peers in a less restrictive atmosphere (MDRI & CELS, 2007).

*California Facilities*

Following a similar pattern as Buenos Aires, California has in-patient and outpatient facilities, halfway houses but also has services within prisons. Although all of these facilities exist at the governmental level, smooth transitions from service to service do not exist, creating additional difficulties for the patient’s movement towards a functioning life as well as movement towards social reinsertion into their community.

Of the inpatient hospitals and clinics, the services that are provided are a diagnostic evaluation, 24-hour a day care, counseling for the patient (and sometimes the family), medication, and some discharge aftercare care. Outpatient treatment is used as a follow-up to inpatient stays and for less severe cases, providing care, but less intensive constant care. This provides the patient with the opportunity to develop their own life while still regulating their symptoms and working out a lifestyle, with some help, that fits their psychological needs. Services that are generally provided are individual, group, and family therapy, information and
referral to specific services that best fit their needs, recreational activities, and socialization (California Gov., 2012).

Halfway houses are provided for people of all ages, providing them with a therapeutic living environment for people who need a more structured lifestyle than what most outpatient care will offer, but also are presently able to care for themselves without being a danger to themselves or anyone else, therefore do not require inpatient psychiatric hospitalization (California Gov., 2012). In this household, services are geared towards the specific needs of each resident, often having the patient become the primary partner in deciding what help they do or do not need. Depending on the severity and the aid a patient needs, they will be directed to a house that will match their need level. Particularly for children and youth who have mental health problems, their facilities will often have additional support because they may have a harder time adjusting to placements. Services at these halfway homes or residential treatment facilities include crisis stabilization, bio-psyhosocial assessment, care management, medication management, therapy, and often for children’s facilities there are on-grounds schools (California Gov., 2012).

The final kind of facility that provides psychological services to people with severe mental health disorder that I will discuss are the services provided in prisons. In California, the prisons will provide services to people who has current symptoms and/or requires treatment for the disorders included on the DSM’s Axis I mental disorders list. Of the mental illnesses that we will be looking at, this includes schizophrenia, bipolar I disorder, and major depressive disorder. The services provided to these inmates are crisis intervention, a bed outside of their cell for severe cases who need to be monitored for usually no more than ten days, psychotherapy sessions, medication, outpatient services such as group therapy, and preparing
the inmate for their discharge back into the community (Mental Health Services Delivery System, 2009).

**Limitations of The System**

Due to this grouping of legislation, policies, methods of financing, and the enforcement of the mental health policies, current treatment is presently quite distant both in Argentina and the United States from what researchers and advocacy workers believe would best help people struggling with chronic mental health disorders. By examining the limitations presented in the section above, there are some key problems present in both environments that are limiting the potential improvement of well-being that the mental health system could provide.

**Buenos Aires**

When comparing California’s effectiveness of treatment with Buenos Aires treatment approaches, there are very similar problems, but they arise from different sources. The same three major barriers to an effective treatment approach are financial limitations, accessibility, and limited alternatives to the traditional treatment approaches and psychoanalytically trained professionals.

Although laws are in place to protect the rights of mental health partners, there continue to be many shortcomings as to the options on how to fund and enforce the laws. There is a disconnect between the ideals of the country and its ability to provide those services to their people. A large reason why this barrier to implementation exists is because of a lack of financial ability to support the laws that are developed. While laws such as the “Mental Health Law of the city of Buenos Aires No. 448” requires the city government to enforce progressive deinstitutionalization and calls for action towards social reintegration of mental health partners, to be able to shut down the mental health institutions there would need to be set up alternative
facilities, but presently Buenos Aires does not have the economic ability to support the
development of or the staffing of new alternative facilities (Moldavsky, Savage, Stein, Blake,
2011; MDRI & CELS, 2007).

The same problem exists in the new National Mental Health Law which states that all
treatment of mental health disorders should include an interdisciplinary team and that it should
exist beyond the institutions or inpatient facilities. This would require much more money to be
funneled to mental health work so that they could attract a wider range of professionals to work
within the team. Additionally, to provide follow-up to partners, although follow-up has been
shown to ultimately be a more cost-effective method of treating mental disorders, there would
need to be an allocation of the mental health fund directed towards follow-up treatments, which
is not very established or well researched yet (Biernie, 2009; Cusack et al., 2010). Until
Argentina can develop a more achievable set of goals and laws for itself, then the mental health
system will continue to underperform since the goals set are too far off from where the system
is presently.

The second problem in Argentina is how accessibility to services, similar to the United
States, is limited. In large urban centers like Buenos Aires accessibility is less severe of a
problem, but in the areas outside of these Argentine cities, facilities and the diversity of
services is deplorable. Particularly in the “villas” or shanty towns where the poorest members
of the community live, generally located on the outskirts of town, there are no health, much less
mental health, facilities present. There is a struggle to get appropriate medication, enough
beds, and basic services for mental health partners (WHO 2011; WHO, 2005; Ablard, 2008).
Because of these limited resources in rural areas of Argentina, even more responsibility to care
for the ill family member falls on the well family members.
Additionally, limited diversity of approaches and number of trained professionals utilized in mental health treatment approaches also hurts the patients who are relying on the system. Of the approaches available, long-term (lasting more than one year) psychoanalytic therapy is the primary focus used when approaching therapy. This is a long-term treatment approach that in crisis situations does not provide immediate relief or aid to the individual struggling with a severe mental health problem. There are very limited short-term behavioral/cognitive therapeutic approaches or more alternative treatment modalities. In fact, 68% of all mental health funding is for long-term inpatient treatment (Moldavsky, Savage, Stein, Blake, 2011). In this kind of drawn-out, therapist centered treatments, the partners are not able to take power of the recovery process themselves. This is also a problem because the long-term therapeutic work is usually psychoanalytically focused. This excessive focus on psychoanalytic work in part due to the history of oppression when mental health workers were forced to go into private practice out of fear of being more easily identified if working for social change (Ablard, 2008). The problem with psychoanalytic therapy is that it is meant for long-term approaches and in-depth analysis of what, in one’s history, has led to their present condition. However, the chronic and severe mental health challenges discussed in this paper require crisis intervention and socialization, not historical insight.

Not only is psychoanalytic therapy the primary option used, but few alternative treatment approaches are offered (Inchaurraga, 2003). Again this traces back to the history of Argentina and the elimination of such treatment methods. Although in recent years there has been a greater focus on social reinsertion, it is still a very uncommon service for clinics or especially hospitals to provide. There is not an established system that smoothly aids a partner’s transition from the intensive inpatient wards, or even the outpatient services, to
socializing with people of all backgrounds and conditions. This generally leads partners to remain in their houses, unmotivated to begin reentry into society, ultimately ending in another relapse. Little by little, people are working to find what alternatives will work best, but there is a way to go before any new treatment models will be implemented, especially because there is limited data or research being done throughout Argentina about the needs of this population or the most effective approaches (Moldavsky, Savage, Stein, Blake, 2011).

There is also a lack of clinical guidelines structuring appropriate medications for different mental health conditions. Leaving it up to individual physicians who are not trained in mental health treatment leads to prescribing medications that are often not necessarily supported by clinical evidence (Moldavsky, Savage, Stein, Blake, 2011).

Another key problem is that mental health training is almost exclusively for psychologists and psychiatrists, not for primary care doctors, nurses, or other non-certified community resources, such as pastors and school personnel (Moldavsky, Savage, Stein, Blake, 2011). As seen in the United States, partners are regularly interacting with people outside of the mental health world and these interactions could be used to create a more fluid treatment approach. Whether it is training local community leaders, religious leaders, school teachers, general practitioners, police force or family members, having more widespread knowledge about these disorders and how to react to them would be very beneficial to the population. For religious leaders and general practitioners who could be in a more therapy-like situation with these partners, they would need extra training. With the inclusion of more people into the treatment approach, not only would some of the stigma hopefully begin to dissipate within the community, but then mental health treatment would begin to seem less daunting if it could be included into a more casual atmosphere as well as going to their therapist. This would also
hopefully take some of the pressure, as mentioned before, off of the family members to be the sole caretakers of their ill family member.

*California*

In the United States, there are three main limitations: financial, particularly given the present economic downturn, accessibility of services, and training for people who will be interacting most frequently with these partners.

Financially, with cuts to Medicaid funding California is forced to cut back on mental health services particularly those affecting the availability of community care (NAMI, 2011). Medicaid is the largest source of financing public mental health services, accounting for almost 50% of all public sector mental health spending. “Many states have used Medicaid creatively to expand their spending on mental health, while decreasing state expenditures. For every dollar that a state spends on Medicaid, it receives one or more federal dollars, depending on the particular state’s relative wealth and it’s corresponding federal Medicaid matching rate” (NAMI 2011). The Federal Stimulus Funds that occurred in 2009-11 temporarily increased the federal match for Medicaid. However, on June 30th 2011, these federal stimulus funds expired and virtually every state was forced to significantly reduce funding for these programs. For example, California has reduced by 21.2% their funding for mental health programs and services from 2009-12. This negative percent change was the 7th highest of all 51 states causing a total drop in mental health funding of $764 million. In the last year (2011-2012), California reduced it’s funding for mental health by 5.9% (NAMI 2011).

All states, and in particular California, are increasingly reliant on federal Medicaid funds to supplement the drop in their own services, the Federal Medicaid budget has ballooned. This trend is unlikely to continue as current federal legislation is proposing stricter limits to
Medicaid funding control that will increase the unmet need for services for poor and severely disabled populations (NAMI 2011). For example, California has proposed cuts of an additional $1.4 billion of state contribution to the Medicaid program (Pecquet 2011). This would in-turn reduce federal matching funds by at least the same amount, further reducing funding for the poorest and most severely impaired of that state.

Due to significant cutbacks in the National Institute of Mental Health (NIMH), there are increasingly limited resources focused on experimental/pilot programs testing the efficacy of short-term treatment programs and the use of non-licensed community members, such as ministers and nursing staff. Furthermore, the National Committee for Quality Assurance (NCQA) is no longer actively funding evaluation programs on alternative treatment approaches for severe mental health conditions such as schizophrenia, bipolar disorders, and other long-term disability mental health issues. Without this data collection and outcome of treatment assessment, it is difficult to develop new and innovative solutions for community based treatment long-term solutions (Luterman 2011).

Additionally since the policies affecting treatment were put in place in the eighties and nineties, the funding has not continued to effectively map to those policies. The money that was once directed towards these community-based treatments no longer exists because it is put in more conventional programs. This is despite the fact that community projects are the ones that have seen substantial improvement in their partners (Gianfrancesco, Wang, & Yu, 2005).

Beyond funding, accessibility to services is another significant barrier preventing mental health partners from being able to receive the help they need (Bonynge, Lee, & Thurber, 2005; Kohn-Wood & Wilson, 2005; MRHRC, 2010). There is not a method in place for ensuring that lower resourced rural communities are receiving the same degree of care as is
present in the urban settings. Since rural areas are not major foci for a government because there are fewer people inhabiting the land, fewer gains received by outside investors, and less vocal population due to their location and separation from the rest of the country, it is these areas that most often are sidelined and given fewer resources or funding than larger counties where there is a greater population. Therefore people struggling with these mental health disorders are left to either abandon their home town so they can receive better structured services or they have to make due with the services present in the community. These services tend to have an inadequate supply of trained psychologists and psychiatrist or community resources and only the most basic therapy. With this limited type of treatment available it is not surprising that the partners are highly likely to end up either constantly in an inpatient ward, jail, or drugged to a state of nonfunctioning. If they remain in the community, again the brunt of the caretaking will fall on family members (Bonynge, Lee, & Thurber, 2005; Kohn-Wood & Wilson, 2005; MRHRC, 2010).

Presently, with the bureaucratic and confusing mental health coverage system, people with mental health disorders must untangle the confusing web of Medicare, SSI, SSDI, and Medical to be able to cover the many costs of their medication, therapy, housing, and outpatient services. For someone who is not suffering from hallucinations or severe depression it would be a struggle to understand what services are covered by which policy, so expecting partners to maneuver through that system alone seems overly hopeful. If they cannot decipher the system, then they are left without a mode of paying for any mental health services. That significantly limits the accessibility they have to any mental health services.

A final main shortcoming of the treatment approaches in California that I will mention is that there is extremely limited training given to people interacting daily with people with
mental health disorders (Chien & Norman, 2009; Fox, 2012; Goldberg-Arnold, Fristad, Gavazzi, 1999; Lefley, 1997). This includes people such as family members, religious leaders (priests, rabbi, etc.), community leaders in youth groups or community centers, or general practitioners working in local hospitals. When approaching mental health treatment, there is often an elitist attitude towards who can treat severe mental health issues; that only psychologists, psychiatrist, or sometimes social workers can affectively help people struggling with mental disorders (Carr et al. 2004). However, if we can utilize the wide network of people interacting with this population, then not only can we make treatment more casual and less disruptive to their normal schedule, but we can also hopefully lessen the burden placed on the caretakers that usually are the main community members dealing with these problems daily.

Family Needs

To understand why these limitations are so harmful to the well-being of partners and their home environment, it is essential to look at the difficulties and needs of their caretakers. Even before official diagnosis or emergence of full symptoms of a mental disorder, often family members are already accustomed to having difficulties interacting with or observing strange behavior by pre-morbid family member (Lefley 1996;1997a; 1997b; Bernheim & Lehman, 1985; Stein & Wemmerus, 2001). This creates stress within the family, but does not usually cause the kind of distress and conflict that occurs when the disorder is fully active.

When the symptoms fully emerge, there are new difficulties that the family must face both with and without the ill family member. First, when the partner is hospitalized, there is separation between the family and the partner, creating more tension and lack of communication between the family and partner (Marsh & Johnson, 1997). Because mental health treatment often takes partners outside of their environment, provides them with
stabilizing treatment, and then discharges them back to where they were before (home, halfway house, or the streets), when they are placed back in their environment, the family is unsure of the condition of their loved ones (Lefley, 1997).

The studies that have addressed the return of family members to the household highlight that the main challenges are watching for the reoccurrence of symptoms that are difficult to foresee, causing anxiety and family disruption. Additionally, the family has a sense of loss both for the loss of potential for their family member’s future and difference in behavior. This is especially difficult to handle because as the symptomology decreases, families often begin to hope that this is the mark of improvement in their loved one’s disorder (Bernheim & Lehman 1985; Eakes, Walsh, Markowski, Cain, & Swanson, 1997; Stein & Wemmerus, 2001). If that pattern of improvement does not continue, then they feel the loss once more as they see their loved one struggle to handle their behavior and disorder.

For the parent dealing with a child with a mental disorder, common emotions that are experienced include anger at their own helplessness, guilt for not being able to care or protect their loved one or for putting them into institutionalized care, an intense sense of loss at the potential they may have seen in their child, and concern about the future care of their child (March & Johnson 1997, Lefley 1997, Kohn-Wood & Willson 2005). Siblings struggle with embarrassment of their sibling’s behavior, distancing from the family, resentment about unequal parental attention, and also concern that they could also either be carrying genes that they could pass on to their children or that they will also start showing symptoms (Lefley, 1997).

Despite this litany of difficulties that family members suffer, recent research has recognized the positive effects of caring for an ill family member. These include the resilience
and gratification experienced from the role of a caretaker as well as the increased probability in addition to the increased probability of sustained improvement of the partner (Pickett-Schenk, Bennett, Cook, Steigman, & Lippincott, 2006; Lefley, 1997).

Because of deinstitutionalization, families are the ones who often spend the most time with them and are the primary caregivers. They also are the ones who generally know the most about the partner’s history, personality, and also have insight into the patient’s living situation. Therefore it is important to make them a larger part of the treatment process. To make that happen it is important to support them as they take on the difficult task of being the primary caregivers. Providing them with community based support and bringing them into the treatment process as active collaborators in developing programs to fit the home environment will significantly help their loved one move more steadily towards improved well-being (Fox, 2012; Goldberg-Arnold, Fristad, Gavazzi, 1999).

Towards a More Comprehensive Community Approach

Through the history of mental health treatment both in Argentina and the United States, the same systemic problems have occurred significantly limiting the possibility of ongoing progress for partners with chronic and severe mental health disorders are entered into a system where their progress is stagnant, limiting their ability to find a role in society. By taking a more community-oriented approach to treatment, the stigma of the illness can be reduced, allowing the partner to more rapidly reintegrate into a more normalized part of society when released for inpatient facilities. Furthermore, if communities can take over a more significant role in the treatment of mental disorders, this creates a more supportive ecosystem and helps struggling families feel less isolated. Bringing the community into the treatment, eases some of the shame
and fear that prevents families from sharing the burden of caring for their loved one and increases the probability of long-term reentry into society.

Ultimately, although community treatment does place more emphasis on the role of family members, it also brings a larger support system and basis of caregivers to both the family members and the people struggling with their mental disorder (Pernice-Duca, 2010; McDonell & Dyck, 2004). For chronic mental health conditions, treatment that is not implementable outside of an inpatient hospital is of limited value. Long-term treatment must be accessible for successful reintegration into society. Because these are chronic conditions, without long-term systematic treatment, the dips down into psychosis or depression grow ever more frequent and severe. For all of these reasons, community care becomes the model of treatment that is essential for providing care for mental health partners.

In creating a comprehensive treatment approach from looking at family needs and dynamics, there are three key aspects of treatment that are important to address: the needs of caretakers of mental health partners, ability of caretakers to work as collaborators in treatment suggestions/enforcement, and movement towards social involvement of both the partner and family members in supportive communities.

**Needs of caretakers**

Helping helpers is based on the idea that the people serving a challenging population often have needs that are not addressed while they are caring for these other people in need (Bernheim & Lehman, 1985). To address this need, helpers and caretakers are suggested to find solutions that will relieve some of the stresses that are put on them in their role as a supporter. In the context of a family member caring for an ill family member this includes caretaker therapy, education about the mental health system, common symptoms, and
productive responses to symptoms, support groups, and relief from financial distress (Hatfield, 1978; Bernheim & Lehman, 1985; McDonell & Dyck, 2004; Lefley, 1996; 1997b; Goldberg-Arnold, Fristad, & Gavazzi, 1999). Each of these aspects of help provide relief and support in dealing with situations as challenging as watching a loved family member experience such extreme changes for their future and ability to relate to people in the same way. Therapy for the family members, whether individual therapy, therapy with the family excluding the ill family member, and/or therapy with the entire family all serve an important purpose in reestablishing trust and understanding of one another within a family context.

Family psycho-education is another key aspect to establishing an understanding what it is like to have a mental disorder and what behaviors are normal (Bernheim & Lehman, 1985; Goldberg-Arnold, Fristad, & Gavazzi, 1999; Eakes, Walsh, Markowski, Cain, & Swanson, 1997). Psycho-education is in response to many families stating that they want more information about the symptoms, treatments, and also want suggestions on how to react to certain behaviors. With that information, the family members are far more capable of handling difficult situations that occur within the community and the possibility of that occurring becomes a less anxiety provoking idea. Also, with a consistent form of care, the ill family member has a less disruptive and unpredictable response leading to fewer negative reactions to emotional stimuli (Lefley, 1996; 1997b).

For taking care of the needs of helpers, support groups are essential to have as an accessible resource for family members and partners (Drapalski et al., 2008). For family members, taking care of a loved one with a mental disorder can be very isolating and saddening. To have a weekly or biweekly meeting of a group of people from the community who have gone through or are presently going through similar events, can have a huge impact
on the attitudes a caregiver has toward their loved one’s behavior (Chien & Norman, 2009). Knowing how other people have struggled and worked through similar difficulties can make the process of caring for a challenging family member moderately easier. Also, not having to hide their home life from everyone, which is a common reaction when something so troubling and personal is going on at home, and feeling able to include others in the struggles that a caretaker takes on can help normalize the experience of taking care of a sick family member (Chien & Norman, 2009; Lefley, 1996). It can take some of the weight off of the caretaker if they can see they do not need to give up their lives to take care of their loved one. They can both maintain a life outside of the child or spouse and not feel as if they are neglectful.

Beyond support groups or general support coming from family and friends, it is important that we change the way that psychologists, community workers, social workers, and religious leaders interact and support the family (Fox, 2012; Riebschleger, 2001; Carr et al., 2004). Presently, there are major shortcomings visible when looking at the relationship between the family and these aid providers. But to fix those shortcomings, aid can be provided in a slightly different way and still improve upon the results. Following the model of assertive community treatment (ACT), an intensive approach to mental health care delivery that works to get people with severe and chronic mental illness involved in the community again, including job training, opportunities for social relationships, residential independence, money management, physical health, and overall increased well-being (NAMI, 2007; Smith, Jennings, & Cimino, 2010; Sono et al., 2012). This is accomplished through services such as home-visits, 24/7 availability of their staff, and care being molded specifically to the environment of the partner in need. Another version of that model is the forensic assertive community treatment (FACT), which provides the same basic services, but the aid is directed toward
mentally ill offenders who often cycle through the prison system (Cuddeback, Morrissey, & Cusack, 2008; Cuddeback & Morrissey, 2011; Cuddeback, Pettus-Davis, & Scheyett, 2011; Lamberti, Weisman, & Faden, 2004; Mohan, Slade, & Fahy, 2004).

In addition to the ACT and FACT models, training community members is also crucial for improving the support that partners and family members receive (Carr et al., 2004; Dupère & Perkins, 2007). When training religious leaders to supplement the role of psychologists, they can then identify people who are struggling with a mental disorder, can advise them, listen to them and their families, and provide therapy and care that may appear less intimidating than going to see a psychologist. Similarly, in training community leaders who are active in the community and interact with many of the community members, they can both set a model of how other members of the community can respond to people struggling with a mental illness. With that kind of support, negative reactions towards mentally ill community members can be minimized and the community becomes a less intimidating and anxiety provoking place to be. Finally, having professionals such as police and general practitioners also be trained in how to respond to a person having a psychotic break or a negative reaction to a stressor limits the need for extreme measures, and can instead be handled in a calm, therapeutic way that helps the partner. If they are brought back to an inpatient care facility because of an extreme reaction to a stressor instead of remaining in their community, that can bring the partner back to ground level in terms of their improvements in reentering society again. Training each of these people who otherwise would not be very knowledgeable about what it is like to have a mental illness or how best to react and/or treat them, also begins to erase some of the stigma that has long been present for people with mental disorders.
A final aspect of providing support and care to families struggling with mental illness is providing a kind of substitute care (Lefley, 1996; Golcman, 2012). Often either families are not able or interested in caring for their mentally ill family member. This creates the need for alternative housing such as half-way houses that provide therapy, a social atmosphere, care, and teach the inhabitants how to live more independently when possible. This takes some of the burden off families, but still provides people with a healthy environment to go to so they are not forced to live on the streets.

Caretakers as Collaborators

The second segment of community care is to see the caretakers as people who can be active participants of the process towards well-being (Lefley, 1996). A key problem that exists with the present system is that intensive services are only provided for a short time and once released, partners are not provided any kind of consistent care. If professionals, community workers, and family members all work together to find a program that works for each of them, then providing constant care is less intensive, allowing for family members to not feel as burned out and exhausted. If we do not use their knowledge, then the families are still dealing with the challenges of trying to help their mentally ill family member, but have no recognition or assistance unless there is an extreme situation.

Additionally, family members see their loved one most and generally are the people who know them best, so to not utilize that information is hurtful to the progress of the partner. Therapists need to be in active communication with the families to see what the present needs of the partner are, and what kind of treatment would be feasible within the environment at home. If therapists try to treat a partner without considering where and by whom it will be implemented by or affected by, there are very limited successes that can occur (Fox, 2012).
Social Involvement

A final and equally vital part of community treatment is establishing social reinsertion for families and partners (Pernice-Duca, 2010; Pickett-Schnek, Bennett, Cook, Steigman, & Lippincott, 2006; Lefley 1996; Chien & Norman, 2009). Following the emergence of a psychological disorder in a family, both partners and families often feel isolated and unsure of how to reengage with their community. This often creates more tension and resentment within the home, worsening the symptoms of the partner and the reactions family members. If, however, they can both find ways to engage in activities outside of the house, then this has been shown to significantly affect the functioning of a family. Joining social outing groups, work programs, art classes, or any kind of club allows people to have social interactions, learn skills, develop confidence, and get some separation from the stress within the home or hospital. This can help the other family members to see their loved one as more than just a helpless victim or dependent member of the family. It gives them hope and shows how at least in little steps, their loved one can care for him or herself (Lefley 1996).

Cost Assessment

In assessing the effectiveness of these treatment approaches, it is essential that we also consider the viability of setting up these treatments based off cost effectiveness and the government’s willingness to try these alternative measures. Research has been conducted on the costs of standard and community care as well as the difficulties in attaining accurate assessments of these costs. These studies have specifically looked at family interventions and housing alternatives to see how we can format care that aids all actors in the treatment process (Gianfrancesco, Wang, Yu, 2005). Treatment effectiveness research has found that providing family management, behavioral intervention, and social support groups all significantly
improve social reengagement and lower the probability of rehospitalization (Mihalopulos, Magnus, Carter, Vos 2004). Beyond lowering the disability-adjusted life years, it also substantially lowers the cost of treatment (Mihalopulos, Magnus, Carter, Vos 2004).

For housing alternatives, studies have specifically examined homeless populations and people who need crisis housing. In studies by Birnie (2009), researchers calculated the costs from the societal perspective and also from the costs on the family to understand the effect on all the actors in the mental health care system. Birnie’s study found intensive case management to be more cost effective than standard care from the governmental and societal perspective overall, even though agency costs were significantly greater in intensive case management. Ultimately, it is difficult to know the precise costs of either present or proposed treatments because of the many variables at play. This clearly needs to be the focus of additional research.

Other studies have investigated what kind of housing support is most effective and cost effective. One of these examined how rent subsidies, intensive case management, and standard care compare, ultimately finding that providing partners with rent subsidies, with or without case management, is the most effective way to ensure partners are able to sustain their living situation; partners had 16% more housed days when provided with subsidized care rather than only providing case management and 25% more housed days than when only providing standard care (Rosenhcek, Kasprow, Frisman, Liu-Mares 2003). From the cost analysis, subsidized rent was found to be 15% more costly than standard care, costing $45 more than standard care for each additional day housed. But this trade off of slightly more expensive treatment for superior housing outcomes has been argued by the authors that it is the worthwhile trade off (Rosenhcek, Kasprow, Frisman, Liu-Mares 2003).

Conclusions
While Argentina and the United States have different challenges and barriers to effectively treating their most significantly impacted mental health partners, there is increasing evidence to suggest that a more comprehensive, community based treatment model could speed social reintegration and increase long-term emotional stability for chronic partners in both countries. These treatment models would include the following components:

1. Psycho-education for caretakers covering available services, common symptoms, and ways to respond to partner’s behavior
2. Improving communication between mental health workers and family members
3. Providing substitute care and housing for partners
4. Utilizing the caretaker’s knowledge to format partner specific care
5. Creating support groups for families struggling with mental disorders

With relatively insignificant investments in community care, a series of minor alterations of the present systems could lead to a far more effective way of working with mental illness. Given the relative wealth of both countries, this type of intensive treatment would seem to be well within our capabilities if we are willing to reprioritize our budget allocations to support our most chronically impaired citizens.
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