That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary
interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make
one despair of political humanity.         George Bernard Shaw, The Doctor's Dilemma

Conversation enriches the understanding, but solitude is the school of genius. –Edward Gibbon

Course Description

This course will cover the various mental health services and programs for adults, children, and
youth. It will discuss the roles that social workers perform in promotion, prevention, treatment
and rehabilitation services to persons with mental illness, developmental disabilities and
substance abuse problems. Contemporary policy issues in mental health services, particularly as
they relate to larger political and social trends will be discussed. Legislation, ethical issues,
stakeholder controversies and social movements affecting services to persons with mental illness
will also be discussed. The historical context of services marred as they were by social control
measures and stigmatizing practices will be assessed. The impact of race, gender, ethnicity,
sexual orientation, and social class on mental health policies and services will be examined. The
course will also examine the potential and actual role of various self-help, mutual aid, and
natural/informal helping systems.

Course Content

The process and politics of mental health policy making and program development will be
examined from the perspective of historical, contemporary, and future models of the mental
health system. Alternative approaches to defining mental health and mental illness,
developmental and other disabilities, and substance related disorders will be studied.
Epidemiological findings related to the incidence and prevalence of disorders and the utilization
of mental health services will be examined. Local, state, and national models of mental health
programs including self-help and advocacy programs will be reviewed. These programs will
represent a range of approaches to promotion, prevention, treatment, and rehabilitation services,
along with a range of financing, and service delivery mechanisms. Individual rights, especially as
they relate to involuntary treatment and professional conduct will be discussed.

Attention will be given to persons with mental illness, developmental disabilities, learning
disabilities, and substance abuse disorders—or combinations of these conditions—with a special
focus on individuals with severe and persistent mental conditions. US mental health policy will
be examined as it is enacted in programs and services, social entitlements, financing
arrangements, and organizational missions. Associated ethical and value dilemmas will be
examined within an American as well as comparative historical and cultural context. The major
focus of the course will be on public policies and services, with simultaneous examination of the
relationships among the increasingly overlapping public, non-profit and for-profit sectors. Special
consideration will be given to how the contemporary mental health system is experienced by economically disadvantaged persons, women, gay male, lesbian, bisexual and transgendered persons, and persons of color.

OBJECTIVES:

1. Demonstrate knowledge of the historical context of mental health policies and services, and apply this knowledge in making a critical analysis of existing and proposed mental health systems.

2. Identify the social work practitioner’s role in mental health policies and services in relation to: 
   a) initiating and modifying policy and programs through their service providing activities and other professional activities, e.g. advocacy, public education, service coordination.
   b) applying the values and ethics of the social work profession to the mental health field, especially the rights of individuals regarding commitment, treatment, and social services.

3. Explain how public health concepts and epidemiological data are used in developing and changing policies and monitoring mental health programs.

4. Identify and analyze the effects of oppression, discrimination, stigma and other negative social influences on consumers of mental health services.

5. Analyze current mental health policies, legal issues, delivery systems, service settings, target populations, service approaches, in relation to contemporary social work practice in mental health.

6. Use knowledge about the etiology of mental illness and other disabilities and the effects of labeling to design prevention and promotion programs for the prevention of illness and promotion of health.

Relationship to Curricular Themes

1. Multicultural Issues and PODS concerns (Privilege, Oppression, Diversity, Social Justice)

Multicultural issues are presented in relation to the various definitions of mental health, mental illness, disabilities, and substance related disorders. Data from epidemiological studies are examined in order to focus on racial/ethnic/cultural groups and other populations at risk in regard to (a) incidence and prevalence rates; (b) acceptability, access, availability, and utilization of services.

INCIDENT

Once riding in old Baltimore
Heart-filled, head-filled with glee,
I saw a Baltimorean
Keep looking straight at me.
Now I was eight and very small,
And he was no whit bigger,
And so I smiled, but he poked out
His tongue, and called me, "Nigger."
I saw the whole of Baltimore
From May until December;
Of all the things that happened there
That's all that I remember

Countee Cullen (1903-1946)
2. Social Change and Social Justice

The study of the mental health service delivery system provides students opportunity for assessment of the system in terms of injustice and the effects of stigma and discrimination or those with psychiatric labels to populations at risk. The objectives of system improvement and social justice are explored in relation to legal issues and individual rights that pertain to mental health policy making and program development.

By permitting chronic patients to live on the streets, clothed in tattered rags, scavenging through trash for sustenance, and sleeping over street grates for warmth, have we not allowed the concept of least restrictive environment to reach its surrealistic endpoint?” Frank R. Lipton, 1993.

3. Promotion and Prevention

An examination of the community mental health movement allows for an emphasis on promotion of mental health and prevention of mental illness and disabilities is explored in the context of research on risk and protective factors related to mental health prevention programs and how the knowledge can be translated into effective interventions.

4. Social Science

Social and behavioral science conceptual frameworks and empirical findings are presented throughout the course on such topics as: epidemiology of disorders and disabilities; causes of illness and disability; program evaluations on the effectiveness of community-based mental health programs; financing of mental health services; and services to women, ethnic minorities, and economically disadvantaged populations.

Relationship of the Course to Social Work Ethics and Values:

This course will examine current ethical issues and controversies in the field of mental health policies and services. The NASW Code of Ethics will be used to inform practice in this area. Students will analyze ethical issues related to: stigmatization and psychiatric labels; client confidentiality; client rights and prerogatives, especially the rights of populations at risk and those related to civil commitment and treatment; prevention and elimination of discrimination; equal access to resources, services, and opportunities; respect for the diversity of cultures; changes in policy and legislation that promote improvements in social conditions; and informed participation of the public.

A Personal Note: If you need accommodation for a disability (mental or physical), please make an appointment to see me early in the term so that we can make the necessary arrangements.

SOURCE MATERIALS

In the keeping the mind open department, the Journal of the American Medical Association commented (10/14/39) on arguably the most influential book in the health and human service literature, Alcoholics Anonymous. [It is] “a curious combination of organizing propaganda and religious exhortation. The one valid thing in the book is the recognition of the seriousness of addiction to alcohol. Other than this, the book has no scientific merit or interest.”
All required readings are accessible online. In Ctools, click on Library Reserves.

They are also accessible via Mirlyn <http://mirlyn.lib.umich.edu/>. Click on the link at the top right corner of the page - GO TO FIND OTHER LIBRARY CATALOGS. Scroll to the bottom of the first column, then click on the Course Reserves link. For Course Name, enter sw 636 and click on SEARCH. Then click on Instructor. If a link doesn’t work, try it later (some of the external sites may be down for short periods). If a link doesn’t work later, please contact the library, and notify me.

Important resource documents include the SAMHSA Transforming Mental Health Care ..., the two Surgeon General’s Reports, the President's New Freedom report and Michigan Mental Health Commission Report. They are available on the Internet, and sometimes may also be available in print form either at no charge or at nominal cost. All other readings will be on electronic reserve:

Michigan Mental Health Commission Report, October, 2004
http://www.michigan.gov/mentalhealth


A model consumer-oriented Internet site
http://sandiego.networkofcare.org/mh/home/index.cfm

Excellent course specific sites:
http://www.lib.umich.edu/socwork/rescue/sw636.html
http://www.lib.umich.edu/socwork/rescue/ebsw.html
http://www.thearc.org/

https://ctools.umich.edu/portal

Also try these “local sites”:

http://www.mdeh.state.mi.us/ Michigan Department of Community Health
http://www.co.washtenaw.mi.us/DEPTS/CMH.HTM
http://namiwc.org/  (NAMI, Washtenaw County)
http://mi.nami.org/ (NAMI, Michigan)

Some Thoughts on Practitioner Relevant Analysis of Implemented Policy

Although policy can be defined in various ways, it may be fruitful to think of policy as a course
or pattern of action that is reflected in programs and services. The services often are generated by
“policies” set by legislative, executive, and court officials; by employers and insurance
companies; agency board members and executives; professional associations, etc. It would be a
mistake, however, to assume that policies promulgated at these levels are equivalent to what is
implemented at the services or practice level. High level policy is usually mediated, interpreted,
and sometimes transformed by practitioners. Consider, for example, the variation in the way
confidentiality, service limits, and fees are handled in agencies presumably governed by the same
policy directives. Hence we must be concerned not only with what is promulgated but also with
what is implemented. In this course we will often focus on implemented policy, that which
actually takes place as services are provided, or not provided. This focus is obviously relevant to
both IP and Macro specialists

Policies, if considered to be a course of action or a recurring pattern, are not necessarily recorded
in written documents; indeed they may be quite at odds with what is in written in published
documents. Sometimes policy exists without a published document, e.g., requiring certain cost-
saving measures. Other times, written “policy” documents are not policy at all if they do not
influence the course of action.

You may be able to think of an agency policy that is not written or recorded like the one requiring
that preference be given to less costly services. Or, on the other side, a “policy” to compromise
paper work when it conflicts with client services. One you may be familiar with is the common
policy to discourage Axis II diagnoses when they jeopardize managed care payments. Still
another may be the tendency of some utilization reviewers to be more generous in authorizing
outpatient sessions when they have had previous positive experiences with the provider.

Policy is the end result of a number of influences. We can start with broad cultural, economic and
political influences (e.g., the impoverished general funds of state governments). These influences
shape laws, court decisions, managed care strategies, service bureaucracy directives, Medicaid
and Medicare policies, employee benefit programs, funding formulas, insurance regulations,
agency organizational structures and so on. These “big picture” influences are in turn shaped or
mediated by local practices. Indeed, big picture influences are sometimes substantially altered or
even reversed at the implementation level (e.g., as practitioners interpret benefit policies or
bypass red tape perhaps using the backing of consumer groups or NAMI). Local actions may also
prompt “big picture” changes via feedback loops between system levels (e.g. in highlighting the
risks of suicide or homicide when adequate emergency services are not in place).

Implemented policy is influenced by such factors as the information, skills, network ties, and value commitments of the practitioner. These more local and immediate factors moderate—both for good and ill—the way the big picture influences are translated into actual practice. Thus an important focus of the course will be on how the implementing practitioner can contribute to effective policy by her interpretations of directives and discretionary actions. And we’ll also note that as the practitioner’s discretionary actions become patterned, he or she is making policy in a real way. Some of these practitioner generated policies may be inspired or energized by the advocacy efforts of consumers and family members. The efforts of practitioners and clients may be combined to work toward ameliorating joblessness and homelessness, combating stigma, and changing insensitive and ineffective aspects of the service system.

Policy effectiveness should be measured in terms of the quality of services delivered and in terms of the outcomes for clients or customers. This means they must meet PODS standards, that is pass examination when screened for the invidious consequences associated with lack of Privilege, Oppression, too little Diversity, and defective Social Justice.

A word about how we refer to the people we serve: we will consider the politics and the propriety of referring to people who have contact with the system as consumers, survivors, customers, self-identified persons with an illness, clients or patients. We will also consider why it stigmatizes people and creates deviance to refer to individuals as “schizophrenics, bipolars, or borderlines” rather than as people with a particular disorder, e.g., schizophrenia.

In this course, particular attention will be given to community-based services for people with serious mental illness. These services can be grouped as follows: 1) "case" management (a term for which no agreed upon substitute has emerged despite the ease with which its dehumanizing connotations can be deconstructed), and assertive community treatment (ACT) programs; 2) psychosocial rehabilitation programs including Fountain House, Fresh Start, Art Oasis, and Full Circle community programs with special emphasis on the most promising elements of their supported education and employment programs; 3) supported housing programs including Fairweather Lodges, Avalon residences, adult foster care homes, supported apartments, and nursing homes; 4) consumer-provider programs including JIMHO and other peer counseling and consumer advocacy and drop-in programs, and 5) Self-help, mutual aid and support programs including Recovery Inc., Depression and Bipolar Support Alliance (formerly the Manic-Depressive and Depressive Association), Schizophrenics Anonymous, National Empowerment Center affiliates, National Mental Health Consumers Association, and numerous other potentially relevant non-mental-health-specialized groups such as Alcoholics Anonymous, Compassionate Friends, Overeaters Anonymous, Adult Children of Alcoholics (and Al-Anon) groups.

Know that many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues — and in terms of the problems of history-making. Know that the human meaning of public issues must be revealed by relating them to personal troubles — and to the problems of individual life. C. Wright Mills. The Sociological Imagination. New York: Oxford, 1959, p. 226.

Counterpoint: Not all personal troubles (e.g., a child’s death from cancer) have an immediate cause or solution in the public sector. To what extent could the horror of the tsunami or Katrina have been avoided by different socio-structural arrangements?

Also do some agencies “address” problems seemingly to assuage the community’s conscience while doing little to alleviate the problem. Might they in fact serve to discourage potentially helpful individuals from providing meaningful assistance. Those who hold such views favor more personalistic approaches such as those promoted by the Catholic Worker/Hospitality House movement founded...

…[in] 1955, … there were 1.7 million episodes [of care]. Episodes increase impressively between 1992 and 2000, from nine million to thirteen million. Similarly, numbers of mental health providers have risen dramatically. Although the supply of traditional providers such as psychiatrists and psychiatric nurses has increased only modestly, there have been larger increases in psychology and social work and very large increases in counseling and psychosocial rehabilitation. Patient care full-time-equivalent (FTE) staff in mental health organizations increased from 347,000 in 1986 to 532,000 in 1998. Mechanic, D., & Bilder, S. (2004). Treatment Of People With Mental Illness: A Decade-Long Perspective. Health Affairs, 23, p.86.

ASSIGNMENTS

Assignment 1  https://ctools.umich.edu/portal
Select five readings for critique in CTools. Each critique should be approximately 200 words (more if you wish). It should discuss how some aspect of the information or ideas in the reading can be applied to improve mental health services or social work practice. This calls for your interpretation and analysis of the reading rather than a summary or a paraphrase of the reading. Try to be concrete, and use examples where possible. Your critique should incorporate your unique impression of the reading, and not be simply a reply to someone else’s critique, though you may want to refer to other’s critiques.

Critiques should be posted by the Friday before the session in which the reading is due to be discussed. Please do not use attachments as they are cumbersome. Instead copy and paste from your word processor.

If you post a critique, you will be expected to contribute to the class discussion about the reading even if the discussion comes up after the assigned date. Remember what you say.

1st critique due 1/20
2nd critique due 2/3
3rd critique due 2/17
4th critique due 3/17
5th critique due 4/7

Thoughtful and timely critiques and responses will contribute up to 15 points toward your grade. Careless, missing, or late critiques and responses will result in deductions. Qualitative feedback on your critiques is available during office hours. Bring a print copy of your critiques.

Assignment 2: Policy (Program) Development and Analysis paper:

Early on I would like to meet with you to discuss your plans for the paper. To find the conference helpful, you do not need to have a firm topic or be ready to begin work on the paper. In fact I can help you clarify your interest, formulate your topic, begin an outline, construct a literature search strategy, and develop your ideas about how your paper will apply to social work practice. If my
office hours don’t work for you, let me know what times will work. Don’t wait until the last minute.

In the academic world, most of the work that is done is clerical. A lot of the work done by professors is routine. Noam Chomsky 11/2/03 NY Times

“Everybody is ignorant only on different things.” Will Rogers

a) Write a paper on any topic related to mental health services or policy. You are strongly encouraged to confer with me before starting on this paper.

“If you do not find a thesis, your essay will be a tour through the miscellaneous. An essay replete with scaffolds and catwalks – ‘We have just seen this; now let us turn to this’ – is an essay in which the inherent idea is weak or nonexistent. A purely expository and descriptive essay, one simply about “Cats,” for instance, will have to rely on outer scaffolding alone (some orderly progression from Persia to Siam) since it really has no idea at all. It is all subject, all cats, instead of being based on an idea about cats.” Sheridan Baker, University of Michigan English Professor, 1950-1984

or

b) Program or Policy Analysis paper
Describe a program that you are familiar with such as a self-help program (e.g., NAMI, Depression and Bipolar Support Alliance, Schizophrenics Anonymous), an ACT or clubhouse program, a shelter or breakfast program, or any of the numerous programs that have been mentioned in this syllabus or in class. The program might be one you have worked in, done your field placement in, or observed over a period of time.

Discuss who actually uses the program and compare the actual users with those for whom it was designed. Describe the service network of which the program is a part, i.e. how people get to the program (i.e., the referral network), and what happens to them after the program. Describe in some detail the actual operations, activities or components of the program, while simultaneously taking care to assess their quality. Include in your description any acts of commission or omission that weaken the program. The idea is to establish a realistic basis for your analysis. The analysis should be based on what the program does and not on what it says it does.

Construct a formal assessment of the program in terms of its: a) accessibility in relation to need and demand b) the quality of its interventions and activities according to accepted standards, c) evidence with respect to outcomes, d) satisfaction of consumers and families, e) costs (total and then broken down by those that are borne by the consumer, family, or third party payer). For example, ACT services may have an annual cost of tens of thousands of dollars though only a little of that is borne by the consumer while most of it is borne by government third party payers. Other services like outpatient therapy may be less costly but impose a significant burden on the consumer because of high co pays or limited insurance (or entitlement benefit) coverage of services. In thinking about total costs, and who pays, it is important to be alert to cost-shifting among various service sectors, e.g., from private-pay services to publicly sponsored programs.

In addition, other evaluative criteria may be relevant depending on the nature of program. If so be sure to incorporate them into your assessment.

In your assessment pay particular attention to how the program responds, or fails to respond, to the interests of people from a various cultural groups such as people of color, oppressed ethnic or religious groups, seniors, women, poor or low income persons, persons with disabilities, or transgendered persons or people with varying gender identities or styles of expression.
Discuss how the assessment might differ depending on whether one’s perspective is from that of a consumer, family member, service provider (and within the provider category distinguish between nurses, physicians, social workers, psychologists, etc.), third party payers, corporate purchasers, tax payers, and other stakeholders in the program.

Lastly, discuss how you would prioritize this program relative to other important or essential programs. Establishing priorities acknowledges the response cost associated with supporting a program which usually results in less support for other kinds of programs.

You may want to confer with me early, perhaps even before you are ready to begin work on the paper—sometimes it’s good to let ideas simmer for awhile. Later when you’re ready to begin active work you’ll be able to move more quickly to sharpen your focus, identify resources, and develop a plan for organizing your report.

All knowledge is not on Google

All papers should have a balance of journal and Internet references. One cannot produce a quality paper without quality references, though quality references alone won’t produce a quality paper. The references should be peer reviewed, evidence-based and current, but recent references should not be favored over more important ones.

At the beginning or end of the paper (or anyplace that suits), describe your search strategy. Identify the keywords you used to search one or more of the following databases: Medline, PsychInfo, Family & Society Studies Worldwide, or another database specific to your topic. Search databases, not clients or servers, e.g., Proquest or Ebsco. Report the results of your search, and discuss the rationale you used to choose the key references for the paper. When you refer to an article in print even though you accessed it electronically preferably via pdf file, cite the primary source, that is the print version. A sufficient number of references will depend on their comprehensiveness and the nature of the paper. However, fewer than six should prompt you to check whether you’ve adequately covered the topic, but again remember quality is more important than quantity.

Some policy-oriented journals that sometimes get overlooked in such papers are: Health Affairs, Health Services Research, Journal of Mental Health Policy and Economics, Journal of Behavioral Health Services Research, Administration and Policy in Mental Health, New England Journal of Medicine, JAMA, Lancet.

The policy paper is due March 6, 35 points. Suggested length 8-12 pages.

Please number the pages of your paper, and do not use folders as they make the papers more difficult to handle. Assignments handed in late will be marked down unless arrangements have been made in advance.

Assignment 3. System Improvement Project.

Injustice anywhere is a threat to justice everywhere. MLK, 1963 “Letter from Birmingham Jail”

Frankly I have never yet engaged in a direct action movement that was “well timed,” according to the timetable of those who have not suffered unduly from the disease of segregation.” MLK, 1963 “Letter from Birmingham Jail”
The system improvement assignment is designed to help you learn to develop new programs/services; modify existing ones; or improve the political or financial context of proposed or already operating programs. This means the goal is not simply to discuss a topic, but rather to present **recommendations with supporting evidence** about how services or policy could be improved in the topical area.

The best lack all convictions, while the worst
Are full of passionate intensity W.B. Yeats

The class will be divided into four system improvement groups. Another purpose of these groups will be to discuss policy issues related to the various video and lecture class presentations.

Although topics and interests will be clustered in several groups, I want to emphasize that the range of appropriate topics within each group can be very broad. Appropriate topics could include any of the following, many of which were referenced in the interest assessment document that you completed. The list includes: the recovery concept; homelessness, complementary and alternative medicine (integrative health), insurance parity, Medicaid, entitlement and discretionary services, criminal/legal system services, program planning models, PODS in the agency environment, infant mental health, services for people with developmental disabilities, involuntary treatment, media events as an opportunity to advance policy agendas, e.g., John Nash, Andrea Yates, Pete Domenici, supportive housing models, supported work or education, vocational and employment services, involuntary treatment, reimbursement mechanisms, access to medications, inpatient and outpatient care, residential treatment, assertive community treatment (ACT), psychosocial rehabilitation, peer support, integrated treatment for co-occurring mental illness and substance abuse, psychoeducation of consumers and families, clubhouses (Fountain House), the consumer movement, advocacy groups, self-help groups, anti-psychotic medications, mood disorder medications, foster care, managed care, prevention, multiple family therapy groups, social skills training, social justice, multiculturalism, cultural sensitivity, feminist services, acute care crisis stabilization residences, intensive outpatient services, co-occurring disorder services (integrated substance abuse and mental health services), third party funded psychotherapy, advance directives, outpatient treatment directives, service disparities (by race, ethnicity, gender, age, disability status, sexual orientation).

The connections among topics such as the above will be used to form the groups

The assignment has two components:

1) Write a paper on your chosen topic. This paper should be about 3-5 pages. It is **due March 27** and is worth **12 points**.

2) A group presentation that is the product of your investigations and policy recommendations. The group should make explicit the links between the independent contributions. The group’s policy or action recommendations should be related to the themes emphasized in the course (multicultural sensitivity, social justice goals, scientific or evidence-based interventions, and as appropriate prevention strategies). As part of the presentation, a brief handout should be distributed with appropriate print and Internet references. An evaluation form also to be developed by the group should include items that refer to the aims of the presentation in specific terms, and encourage written comments.

Following the presentation, each group will review the evaluation forms and assess its presentation according to its own objectives and the criteria set forth in the evaluation form. A
representative from the group will then e-mail me a paragraph summary of the group’s evaluation of the presentation. After reviewing the email summary, I will assign a grade, the same for each member of the group, of up to 8 points. The group norm that I hope develops is that each member is ethically obliged to do a fair share of the work. If for any reason you are unable to participate equally in preparing for the presentation, let me know as I can make alternative arrangements with you. The system improvement presentations will be scheduled **April 3 & April 10**.

**Assignment 4 Exam:** A short-answer essay, take home, exam will be discussed in the April 17 class. The questions will be based on class readings, discussions, presentations and videos. Thus it will be helpful to take notes as you go along. The exam will also be go better if you keep track the names of the persons and incidents depicted in the videos. The exam will be due on **April 24** and counts **30 points** toward final grade.

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Assignments</th>
<th>Points</th>
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<tbody>
<tr>
<td>20-Jan</td>
<td>Ctools (2/3 2/17 3/17 4/17)</td>
<td>15</td>
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<tr>
<td>6-Mar</td>
<td>Policy Paper</td>
<td>35</td>
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<tr>
<td>27-Mar</td>
<td>System Improv Pap</td>
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<tr>
<td>3-Apr</td>
<td>Presentation (or 4/10)</td>
<td>8</td>
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<tr>
<td>24-Apr</td>
<td>Exam</td>
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<td>Final</td>
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**Policy Paper Grade**

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<td>C-</td>
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**Final Grade**

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<td>B-</td>
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<td>C</td>
<td>≤ 64</td>
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From the **Student Guide**

**Grades in Academic Courses**

Letter grades from "A" through "E" are given for class performance. "A" grades are given for exceptional individual performance and mastery of the material. The use of "A+", "A", and "A- " distinguish the degree of superiority. "B" grades are given to students who demonstrate mastery of the material. "B+" is used for students who perform just above the mastery level but not in an exceptional manner. "B- " is used for students just below the mastery level. "C" grades are given when mastery of the material is minimal. A "C - " is the lowest grade which carries credit. "D" grades indicate deficiency and carry no credit. "E" grades indicate failure and carry no credit.

This fine print covers situations that hopefully won’t arise, but just in case, here are the rules: When more than two sessions are missed—however unavoidable or noble the reasons—the grade will be lowered five points for each session over two unless the session is made up. To make up a session find out from other students what was covered in the missed sessions and develop a make-up plan to
be submitted via email for my approval. The plan should focus on the topic of the missed session, and should entail three or more hours of effort.

In fairness to other students, papers cannot be redone for a higher grade except when the initial grade is C+ or below. In that case, and at my discretion, the may be redone and the grade will be the average of the first and second paper. I am, of course, available to meet with you to explain my comments on your paper and to suggest ways to strengthen your work.

If you request reconsideration of your grade, submit in writing your evaluation of the paper and your reasons for the request. If we had a conference about the paper, refer to the understanding we had about the goals and the content of the paper. If there was not a conference, explain how your paper built on the relevant literature (refer to specific citations) and class discussions.

**Preliminary Schedule of Topics, Readings, and Assignments**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Assignments</th>
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<tr>
<td>1-9</td>
<td>The rationale for the course (Mills), the role of providers (Shaw), the practitioners’ influence on policy (Powell)</td>
<td>Policy discussion groups&lt;br&gt;Psychosocial clubhouse programs&lt;br&gt;<a href="http://www.iccd.org/Clubhouse%20Directory/directory.htm">http://www.iccd.org/Clubhouse%20Directory/directory.htm</a>&lt;br&gt;<a href="http://fountainhouse.org/">http://fountainhouse.org/</a></td>
</tr>
</tbody>
</table>

What’s new or innovative in the New Freedom Report? Note lack of reference to organized consumer and family groups DBSA, NAMI, and integrative self-help resources like A.A. for people with co-occurring disorders

Some themes: Population size, prevalence, race, ethnicity, culture, public health approach, need, availability, accessibility, utilization, appropriateness and outcomes

Mental Health A Report of the Surgeon General, 1999
Executive summary, vii-xxi

1-30

Required:
Chapter Two (Culture, Race, and Ethnicity). Culture Counts: The Influence of Culture and Society on Mental Health. pp. 23-49
Topics: Culture of the Patient, Culture of the Clinician, Culture, Society, and Mental Health Services, Racism, Discrimination, and Mental Health, Demographic Trends

Policy Perspectives. Assertive Community Treatment Programs.

2-6

Required:
Evidence-Based Practices Illness Management & Recovery; Medication Management; Assertive Community Treatment; Family psychoeducation; Supported employment; Co-occurring disorders: Integrated dual disorders treatment [Web Page].

Resources:

Michigan Mental Health Commission Report,
Executive Summary pp.1-5 (the print pages, not the pdf pages)

Review websites for research on Major paper and System Improvement Project

http://www.lib.umich.edu/socwork/rescue/sw636-1.html
http://www.lib.umich.edu/socwork/rescue/ebsw.html

Consider how you can use these websites for your System Improvement Project, and your Policy Development and Analysis paper.

**NAMI meeting Feb. 13th** 7:30 St Clare’s Episcopal Church/Temple Beth Emeth, 2309 Packard, Ann Arbor. Bill Feiser and Karen Holman, NAMI of Washtenaw County members
In Our Own Voice: Living with Mental Illness

2-13 “…mental illnesses account for 12 to 13 percent of the global burden of disease, but garner less than 1 percent of health resources. This mismatch is even worse in developing nations…” Arthur Kleinman, Harvard Magazine, Jan – Feb 2005, p. 62
Required:

Treat New York Times and Kaiser article as one reading
NYT-1-9-04HealthSpendingatRecordRate.htm
NYT-12-18-05-HealthCareForAll.doc
MedicaidKaiserAnalysis-11-05.pdf
NYT-11-2-05AetnaPayManageDepression.doc

Resource:

Organizing and financing mental health services
http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter6


Video resources: Four Lives; Bonnie tapes

2-20 Required:


Read and comment on a chapter of interest in the WHO document

Video resources: Untreated serious mental illness, 48 hours

2-27 Spring Break

3-6 Required:

Read one of the chapters on children, adults, older adults.

Children, ch 3; Adults, ch4; Older adults 5
http://www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3

Policy development analysis paper due

NAMI meeting March 13th 7:30 St Clare’s Episcopal Church/ Temple Beth Emeth, 2309 Packard, Ann Arbor. Tom Powell, Does NAMI have anything to offer me?

3-13 Policy making opportunities in agency practice.

Required:


Infant Mental Health; The Long Goodbye

Resources:
Culture, Race, and Ethnicity Supplement

http://media.shs.net/ken/pdf/SMA-01-3613/sma-01-3613A.pdf
African Americans 3
American Indians and Alaska Natives 4
Asian Americans and Pacific Islanders 5
Hispanic Americans 6

3-20 Gender identity and gender expression

Physical Disability

Required:

Mental Illness Stigma: Problem of Public Health or Social Justice?


3-27 Required:


System Improvement Project paper due

4-3 System Improvement Group presentations

Required:

H:\VED\CRS\LehmanPortUpdateNAMI-Winter2004.mht (just the brief Lehman update)

4-10 System Improvement Group presentations

Required:

Powell, T.J., Building a supportive environment for self-help groups and organizations, 2006

Resource:

4-17 Course review and discussion of take home exam

4-24 Take home exam due

References


Kawachi I., Daniels N., & Robinson DE. (2005). Health disparities by race and class: why both matter. Health Affairs, 24(2), 343-52


New York Times and Kaiser articles
NYT-1-9-04HealthSpendingatRecordRate.htm
NYT-12-18-05-HealthCareForAll.doc
MedicaidKaiserAnalysis-11-05.pdf
NYT-11-2-05AetnaPayManageDepression.doc


Psychologist, 50(12), 965-974.


Other Valuable Resources


