FCRC | Viewpoint

Mental healthcare disparities and barriers: Addressing what's keeping disadvantaged patients from getting the care they need

Charalambia Louka[1]
[1] Weill Cornell Medical College, New York, NY, USA

In 2017, 46.6 million American adults experienced a mental health episode.[1] That's 1 in 5 USA adults. Despite the stark prevalence and lasting permeance of psychiatric conditions, such ailments continue to be largely undetected, undertreated, and ignored. Of these 46.6 million people, only 43% received treatment.[2] The reasons behind this healthcare delivery dilemma are vast and complex. Still, three barriers continually appear at the top of the list: scant affordable clinics and therapy programs, lack of information about accessible mental healthcare, and the persistence of mental health stigma.

The AAMC reported in 2018 that there were only 28,000 practicing psychiatrists in the USA.[3] Most recently, a 2014 study found that only 65% of psychiatrists accepted privately insured patients. This was significantly lower than other physician specialists (89%) who accepted insurance.[4] Additionally, psychiatry and psychology visits start at $100 per hour and can run up to $400. A study done in 2016 by the Substance Abuse and Mental Health Service Administration (SAMHSA) on why American adults with mental illness did not seek care found that 41.1-46.2% of patients could not afford the cost, and 19.8-30.1% carried a health insurance that either did not pay enough for mental health services or did not cover any mental health services.[2] What's more, multiple studies over the past decade have shown that lower socioeconomic status is associated with a higher incidence of mental disorders such as major depression, generalized anxiety, and substance abuse disorder.[5,6,7,8]

There exists the presence of a cycle whereby the factors (e.g., poverty, poor social support, and low healthcare literacy) that predispose an individual to a psychiatric disease are the same factors that pose a barrier to treatment. As with all types of medical disease, untreated mental health disorders can be severely detrimental to the quality of life, safety, and the overall health of a patient.[9] Increasing the amount and improving the accessibility of free, low-cost, and sliding scale mental health clinics around the country can target this issue. It has been found that free clinics have been widely used by low-income and underserved populations who otherwise would not have access to care. In 2010 study surveying 362 patients across 172 USA free clinics, it was found that if people did not have access to a free clinic, 23% would utilize emergency room services as primary care, and 24% would not seek care at all.[10] Low-cost community and free clinics have also widely proven to be feasible and efficacious in identifying and treating anxiety disorders, depressive disorders, and other mental illnesses.[11,12,13] Increasing the number, reach and bandwidth of such clinics can provide greater access to mental healthcare among populations who otherwise have little such access.

Albeit scarce in number, this is not to say that community and free clinics do not exist. The Mental Health Association in New Jersey (MHANJ) offers a statewide call center that provides those in need with referral services, care management resources, and various mental health-focused phone helplines.[14] The state of Wisconsin offers a similar service, linking patients with accessible psychiatric and psychologic providers,[14] as do Pennsylvania and Georgia.

Many medical schools in New York City offer student-run free clinics, where patients can receive medications and therapy.

However, as someone who volunteers as a director of one of these clinics, I know from first-hand experience that both external providers and patients are often surprised (and pleased) to hear that our clinic exists. I have received countless emails from nurses, social workers, and primary care professionals who heard about us via word-of-mouth and reached out for a list of free or low-cost care options for their uninsured patients. A simple Google search by state for free or low-cost mental healthcare providers yields broken links, non-comprehensive lists, and outdated websites. The 2016 SAMHSA study mentioned above showed that a major reason why patients do not seek medical care is because of lack of information about where to seek care (28.1-28.4%).[2]

The relatively low number of mental healthcare options is compounded by the fact that patients are unaware of their options and where to seek help. There is a lack of awareness of these options among medical providers, as well. Thus, when a patient does reach out to, say, their primary care provider, the barrier of making an appropriate referral still exists.

Whether it be at the state level or the provider level, we need to increase awareness and knowledge of mental health resources. Mental health clinics can reach out to local primary care clinics and community clinics to let them know of their services and referral process. Primary care referrals to mental health specialists have often proven to be successful and crucial for increasing mental healthcare reach.[15,16] In addition to this, advertising mental health clinics via social media, brochures, and email listservs can help notify patients and healthcare professionals about the clinic's services.[17,18] By getting the word out to healthcare professionals and patients alike, we can increase the number of those able to receive care across the country.

Lastly, we run into the issue of mental health stigma, which has been a running theme in the overarching issue of mental healthcare reception for decades. Despite countless laudatory efforts to reduce stigma in the realm of mental health (i.e., movements such as The National Alliance on Mental Illness's StigmaFree,[19] community-based education programs such as those offered by Mental Health USA,[20] and social media campaigns such as In One Voice[21] in Canada), this issue persists. In 2012, the Centers for Disease Control (CDC) conducted a large-scale study where they found that while greater than 80% of American adults agreed that treatment can help people with mental illness lead normal lives, only 35-67% agreed that other people are caring and sympathetic to people living with mental illness.[22]

We must also consider that stigma against having a mental health disorder is often more robust in minority communities, immigrant cultures, and those from disadvantaged backgrounds. In the 2012 CDC study, it was found that non-Hispanic blacks, Hispanics, and those with less than a high school education were more likely to disagree that treatment is effective.[23] It is common in certain cultural groups to be ostracized for having a mental health disorder and for seeking help in the form of therapy or psychotropic medications.

In order to address mental health stigma and its role in hindering patient mental healthcare delivery, we must continue to foster open conversation and educate patients on the importance of treating mental illness like any other medical condition. Psychoeducation in the form of pamphlets and educational materials has been shown to decrease mental health stigma and increase perceived need for treatment.[24,25] Interactive psychoeducational discussions with healthcare professionals, such as primary care doctors, have also shown to have positive effects on mental health stigma.[26,27] Primary care providers and mental health clinics can collaborate to ensure that patients who may be

susceptible to mental health stigma are aided in the help-seeking process via psychoeducation.

The road to easily accessible mental healthcare for all is a long one, with many cultural nuances, socioeconomic barriers, and systemic hurdles. The efforts to provide care for our mental health patients have been steadily growing in recent years but are still not enough. We must focus on increasing the spread of free and low-cost mental health clinics, alerting primary care clinics and patients alike of available services and resources, and providing psychoeducation to patients that may be hindered by mental health stigma. Through these actions, we can hopefully build a solid groundwork for providing equal mental healthcare opportunities for all.

References

1. Mental Illness Statistics Infographic. National Institute of Mental Health Website. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml. Updated February 2019.
2. Park-Lee E, Lipari RN, Hedden SL, Kroutil LA, Porter JD. Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health. *NDSUH Data Review*. September 2017.
3. Weiner S. Addressing the escalating psychiatrist shortage. *AAMC News*. February 2018.
4. Busch SH, Ndumele CD, Loveridge CF, Kyanko KA. Patient Characteristics and Treatment Patterns Among Psychiatrists Who Do Not Accept Private Insurance. *Psychiatric Services.* 2019;70(1):35-39.
5. Maselko J, Bates L, Bhalotra S, et al. Socioeconomic status indicators and common mental disorders: Evidence from a study of prenatal depression in Pakistan. *SSM - Population Health*. 2018;4:1-9.
6. Reiss F, Meyrose A-K, Otto C, Lampert T, Klasen F, Ravens-Sieberer U. Socioeconomic status, stressful life situations and mental health problems in children and adolescents: Results of the German BELLA cohort-study. *Plos One*. 2019;14(3).
7. Vukojevic M, Zovko A, Talic I, Tanovic M, Resic B, Vrdoljak I, et al. Parental Socioeconomic Status as a Predictor of Physical and Mental Health Outcomes in Children—Literature Review. *Acta Clin Croat*. 2017;56(4): 742–8.
8. Amone-P'Olak K, Burger H, Ormel J, Huisman M, Verhulst FC, Oldehinkel AJ. Socioeconomic position and mental health problems in pre- and early-adolescents: the TRAILS study. *Social Psychiatry Psychiatric Epidemiology*. 2009;44(3): 231–8.
9. Kraus C, Kadriu B, Lanzenberger R, et al. Prognosis and improved outcomes in major depression: a review. *Transl Psychiatry*. 2019;9(1):127.
10. Gertz AM, Frank S, Blixen CE. A survey of patients and providers at free clinics across the United States. *J Community Health*. 2011; 36: 83–93.
11. Soltani M, Smith S, Beck E, et al. Universal depression screening, diagnosis, management, and outcomes at a student-run free clinic. *Acad Psychiatry. 2015*; 39: 259-266.
12. Coulthard K, Patel D, Brizzolara C, et al. A feasibility study of expert patient and community mental health team led bipolar psychoeducation groups: implementing an evidence based practice. *BMC psychiatry.* 2013; 13:301.
13. Liberman KM, Meah YS, Chow A, et al. Quality of mental health care at a student-run clinic: care for the uninsured exceeds that of publicly and privately insured populations*. J Community Health*. 2011; 36(5):733-40.
14. Nguyen T, Counts N, et al. Parity or Disparity: The state of mental health in America. *Mental Health America* 2015.
15. Geissler KH, Zeber JE. Primary Care Physician Referral Patterns for Behavioral Health Diagnoses. *Psychiatry Services.* 2020; 71(4): 389-392.
16. Peterson EL, Pidano AE, Honigfeld L. Pediatric primary care providers' reported likelihood to refer to mental health specialists. *Fam Syst Health*. 2018; 36(3): 410-414.
17. Saha K, Weber I, Birnbaum ML, et al. Characterizing Awareness of Schizophrenia Among Facebook Users by Leveraging Facebook Advertisement Estimates*. J Med Internet Res*. 2017;19(5):e156.
18. Househ M. The use of social media in healthcare: organizational, clinical, and patient perspectives. *Stud Health Technol Inform*. 2013;183:244-248.
19. NAMI: National Alliance on Mental Illness. https://www.nami.org/stigmafree
20. Mental Health USA. https://www.mentalhealthUSA.org
21. One Voice Canada. https://onevoicecanada.org/
22. Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services

Administration, National Association of County Behavioral Health & Developmental Disability Directors, National Institute of Mental Health, The Carter Center Mental Health Program. Attitudes Toward Mental Illness: Results from the Behavioral Risk Factor Surveillance System. Atlanta (GA); *Centers for Disease Control and Prevention*; 2012.

23. Nadeem E, Lange JM, Edge D, Fongwa M, Belin T, Miranda J. Does Stigma Keep Poor Young Immigrant and U.S.-Born Black and Latina Women From Seeking Mental Health Care? *Psychiatric Services*. 2007;58(12):1547-1554.

24. Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Association of County Behavioral Health & Developmental Disability Directors, National Institute of Mental Health, The Carter Center Mental Health Program. Attitudes Toward Mental Illness: Results from the Behavioral Risk Factor Surveillance System. Atlanta (GA); *Centers for Disease Control and Prevention*; 2012.

25. Ividrez, J, Snowden, LR, Rao, SM, et al. Psychoeducation to address stigma in black adults referred for mental health treatment: a randomized pilot study. *Community Ment Health J*. 2009; 45: 127.

26. Hammer JH, Vogel DL. Men's help seeking for depression: the efficacy of a male-sensitive brochure about counseling. *Counseling Psychologist.* 2010;38(2):296–313.

27. Saporito JM, Ryan C, Teachman BA. Reducing stigma toward seeking mental health treatment among adolescents. *Stigma Res Action*. 2011;1(2):9-21.