

5-2014

Systemic Barriers to Mental Health Care: A Qualitative Study

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Recommended Citation

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Systemic Barriers to Mental Health Care: A Qualitative Study

by

Hannah Claire Langholz, B.A., B.S.W

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation

Abstract

This paper explores systemic barriers to accessing mental health care, using Wilber's Integral Model as a framework. A review of the literature presents qualitative and quantitative accounts of medication access issues and consequences, availability of and timely access to providers, patients not being taken seriously, communication between providers, and suggests ways to reduce these barriers. The original methodology involved conducting qualitative face-to-face interviews with mental health professionals from free and sliding scale clinics in the Twin Cities. Results discuss changes in methodology to qualitative questions posed in an online survey format to licensed clinical social workers in Minnesota. Results identify systemic barriers to mental health care, including: how access issues frequently lead to hospital/emergency room use, a shortage of providers, long waits for appointments, and financial/insurance barriers. The results also include specific suggestions to reducing and removing these barriers. Similarities and differences between the literature review and results are discussed, as well as implications of this research to social work practice and policy. This paper recommends future research be conducted directly with in-patient mental health patients. It also recommends that the shortage of psychiatry be studied in order to discover strategies to increase the availability of and access to this service.

Keywords: systemic barriers, integral model, psychiatry, licensed clinical social workers, qualitative surveys, online surveys, mental health care

Acknowledgements

The researcher would like to thank her committee members Sarah, Rachel, and Britta for their support and expertise, and her mom Ann for always believing in her.

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Introduction

Mental illness affects many Americans, both adults and children. According to the National Alliance on Mental Illness, “one in four adults – approximately 61.5 million Americans – experience mental illness in a given year. One in 17 – about 13.6 million – live with a serious mental illness such as schizophrenia, major depression or bipolar disorder” (National Alliance on Mental Illness [NAMI], 2013), and “one fifth of school-age children are also affected by these conditions” (American Psychological Association [APA], 2005). Fortunately, many treatment options exist for mental illness, including psychotherapy and medication. Unfortunately, however, the mere existence of these resources does not translate to effective treatment. Many people with mental health issues receive inadequate or no care. “Approximately 60 percent of adults, and almost one-half of youth ages 18 to 15 with a mental illness received no mental health services in the previous year” (NAMI, 2013). If mental health services exist, why are so many people not receiving them? Several studies place the blame on individuals with mental illness. They claim that people choose not to seek services (Chartrand, Robinson, Bolton, 2012; Collins, Westra, Dozois, Burns, 2004; Gould, Beals-Erickson, Roberts, 2011; Strike, Rhodes, Bergmans, Links, 2006).

Friedman and Stroul’s system of care model suggests that treatment is best administered through the least restrictive environment (Kutash & Rivera, 1995). For example, getting psychotherapy and or medication through an outpatient setting is a less expensive, less restrictive option than receiving such services from a psychiatric hospital stay. The average psychiatric hospital stay is five to 10 days (Depression and Bipolar Support Alliance [DBSA], 2004, p. 5) and the average cost of one day in the hospital in

the U.S. is \$3, 949 (McMahon, 2012). The average visit with a therapist lasts under an hour and costs less than \$100 (Riemersma, 2010). Yet, “mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults ages 18-44” (NAMI, 2013). Why do so many Americans end up in the hospital for mental health treatment, when this is clearly neither the cheapest nor the less restrictive option? I suspect that the answer lies in systemic barriers. When cheaper, less restrictive, proactive, outpatient options are too hard to access, than the more restrictive, reactive, and much more costly in-patient last resort becomes the only accessible option. This study seeks to answer the question: What are the systemic barriers people with a mental health diagnosis experience accessing mental health services?

Literature Review

A goal for growth in the mental health arena is to trend toward providing more community mental health services. Psychiatric hospitalizations are an expensive, restrictive approach and can be reduced through the provision of preventive, less restrictive, more accessible, and cheaper community based mental health care. Access to mental health has been studied in various ways. Populations sampled are varied and include psychiatrists (Huskamp et al., 2009; Mościcki et al., 2010; West, Rae, Huskamp, Rubio-Stipeć, Regier, 2010), family members of children with mental illness (Scharer, 2002; Walter, Petr, Davis, 2006), suicidal men (Strike et al., 2006), participants in psychiatric rehabilitation with diagnoses of either schizophrenia or major depressive disorder (McCabe & Leas, 2008) and state and national samples of adults diagnosed with depression (Chartrand et al., 2012), among others. Methods used in prior studies include qualitative interviews (McCabe & Leas, 2008), questionnaires (McCabe & Leas, 2008),

observational surveys (Huskamp et al., 2009), quantitative data analysis (Chartrand et al., 2012) and mixed methods (Galambos, Rocha, McCarter, Chansuthus, 2004; Mościcki et al., 2010; Strike et al., 2006; Walter et al., 2006; West et al., 2010). The literature was examined for lower-quadrant barriers (Wilber, 2006) (defined in the conceptual framework) to care and their consequences. Several themes emerged from the literature. These themes included: medication access problems related to increases in factors like suicidal ideation and use of emergency services; availability of and timely access to professional treatment; not being taken seriously, and communication between service providers. The literature also made suggestions for improving access to mental health care.

The intersection of medication access problems, increased depression/suicide ideation, and use of emergency services

Having trouble accessing medication was the most frequently cited reason for increased depressive and suicidal symptoms and for increased use of emergency services (like emergency room visits and hospitalization). “Mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults ages 18 to 44” (NAMI, 2013, p.1). Some articles focused on the relationship between medication access problems and emergency service use (Huskamp et al., 2009; Walter et al., 2006; West et al., 2010). Other articles talked about the relationship between medication access issues and suicidal ideation (Mościcki et al., 2010).

Medication access and emergency service use. Both West et al. (2010) and Huskamp et al. (2009) found that patients experiencing difficulty in accessing medication were significantly more apt to end up in the emergency room or hospital. Those who

experienced access problems the most were women with diagnoses or symptoms of major depression or anxiety (Huskamp et al., 2009). According to West et al. (2010), “Patients with a medical access problem attributed to prescription drug coverage or management had a 73.8% expected increase in the overall number of emergency department visits compared to the matched sample of patients with no access problems” (p. 617). Problems accessing medication also predicted longer average acute hospital stays (p. 619). In a qualitative study of parents with children who had been hospitalized for mental illness, nine out of the twelve families interviewed shared that “difficulties adjusting or monitoring medications” was the main reason for hospitalization (Walter et al., 2006).

Medication access and suicidal ideation/behavior. Mościcki et al.’s (2010) study found that “patients who experienced medication switches, discontinuations, and other access problems had 3 times the rate of suicidal ideation or behavior compared with patients with no access problems” (p. 1657). This national study of psychiatrists and patient data found that “more than 1 in 5 patients who had any medication access problems also experienced suicidal ideation or behavior” (p. 1660). That number increased to 1 in 3 patients when the specific access problem was switching medication due to the preferred medication not being covered by insurance (Mościcki et al., 2010). In this case, the consequence of a systemic barrier to medication is increased suicidal ideation, which may lead to a costly hospitalization. A systemic barrier that contributes to the difficulty of accessing medication is the availability of and timely access to professional treatment.

Availability of and timely access to professional treatment

Another systemic barrier to accessing mental health care found repeatedly throughout the literature was that mental health treatment is often unavailable or not easily accessible. Suicidal and depressed patients have a high use of health care services, but low rates of contact with mental health services specifically (Collins et al., 2004). Suicidal individuals do seek out help, but are not receiving the appropriate mental health care (Chartrand et al., 2012). Collins et al. identified a need for more practitioners, specifically specialty mental health providers, as there are currently way more people in need of services than there are service providers (2004). Rural areas are well known for having few, if any mental health resources (Galambos et al., 2004; Gould et al., 2012). Gould et al. (2012) studied state mental health plans and coded them for gaps (meaning a service did not exist) and barriers (meaning a service exists, but is inaccessible). They found that “A lack of service providers was the gap cited most frequently” (p. 769). Psychiatrists are difficult to access in any area, but are particularly hard to find in rural areas.

Concerning timely access to care, multiple studies told stories of people’s unsuccessful effort to speak with professionals (Chartrand et al., 2012; Collins et al., 2004; Scharer, 2002; Strike et al., 2006; Walter et al., 2006). Scharer (2002) interviewed 38 parents of 29 children who had been hospitalized. This sample included 1 private, not for profit hospital and 1 public psychiatric hospital, both with child psychiatric beds. One of the parents interviewed shared, “I tried to reach the doctor for a couple of days and did not even see him or speak to him until my son was being released. And then I was granted maybe a 15 minute time...” (Scharer, 2002, p. 628) Another family in this study reported “trying for months to get suitable assistance for their child” (p. 631). Walter et

al. (2006) interviewed twelve families with children in Kansas state mental hospitals. Families of children on psychotropic medications in this study “frequently voiced concerns about...the lack of timely access to psychiatric consults...” (Walter et al., 2006, p. 617). In a study of suicidal men, many who were admitted to a psychiatric unit expressed frustration with the lack of access to actual care. According to Strike et al. (2006), “Many [psychiatric patients] felt that they sat on the ward for days and were not given the opportunity to speak with nurses or psychiatrists about their problems...” (p. 35). In a study of TennCare - Tennessee’s Medicaid managed care program (Galambos et al., 2004) - recipients, “one respondent describes calling the TennCare hotline several times, and each time spending at least 45 minutes on the telephone. After many telephone calls and writing 3 letters of complaint, the problem was resolved several months later” (Galambos et al., 2004, p. 14). Those who were lucky enough to actually meet with a professional often reported that their meetings did not last long enough to appropriately address their needs (Galambos et al., 2004; Scharer, 2002; Strike et al., 2006;).

Not being taken seriously

In addition to difficulties accessing a mental health professional, patients and parents report that their concerns are often not taken seriously (McCabe & Leas, 2008; Scharer, 2002; Strike et al., 2006; Walter et al., 2006). In a study of parents of children with mental illness, one family tried for months to access mental health care for their child and eventually had to involve their state representative (Scharer, 2002). Another parent in this same study tried “to get her child hospitalized for a year and a half, but it was only after the child cut a peer’s hair in school and threatened to kill the peer that the mental health center responded” (Scharer, 2002, p. 631). Suicidal men interviewed in

Strike et al.'s study expressed that health care providers viewed their attempts to get help as "inappropriate" or "attention seeking," and often turned them away from the emergency room (2006, p.34). In the words of one participant in Strike et al.'s study, "...It's kind of like you feel you've got to turn up the volume loud enough by doing stuff before they take you seriously" (2006, p. 36.) Walter et al.'s study of families of children with mental illness also cited a "sense of not being taken seriously" as a barrier (2006, p. 618). A study of patients with schizophrenia and Major depressive disorder found that these patients also felt that "their physical health concerns were often not taken seriously" (McCabe & Leas, 2008, p. 307). According to this same study, "over half the participants with mental illness gave instances of when they had been in situations in which they felt that the treating doctors were businesslike and impersonal towards them" (p. 308).

Communication between service providers

Several studies identified that communication between service providers was lacking and created a barrier to patient care (Galambos et al., 2004; Strike et al., 2006; Walter et al., 2006). The Walter et al. (2006) study found a "lack of communication and collaboration within and between service systems" (p. 618). Patients in Strike et al.'s study shared that "efforts to receive care were frustrated because they were unable to obtain requested referrals" (2006, p. 34). Respondents in Galambos et al.'s study (2004) of individuals on Tennessee's state managed care plan identified "a problem with the separation of health and mental health care" (p. 10).

Prevention through timely access and integrated services

Several studies offered advice in light of their findings (Collins et al., 2004; Strike et al., 2006; Walter et al., 2006). One study suggested that assuring timely access to

community-based services and medication would prevent acute crises (Walter et al., 2006). Strike's study suggested that "Ideally, each [patient] would have a long-term therapist who would work with him and other health professionals toward building an individualized, integrated system of care with clear goals and expectations of each member of the team" (2006, p.37). Collins et al. (2004) suggested "Increas[ing] collaboration efforts between medical and mental health professionals" and "integrating mental health and health services...[because]...integrated mental health service delivery is substantially more cost-effective than the existing health care system" (p. 600). Collins et al.'s (2004) definition of an integrative model is one that "emphasize[s] a collaborative treatment approach, with patients being co-managed by mental health and primary care providers, and treatment integrating psychoeducation with regard to self-management strategies" (p. 600).

Conceptual Framework

Ken Wilber's Integral Model for Medicine provides a helpful framework for looking at systemic barriers. In his book *Integral Spirituality*, Wilber explains how a map of four quadrants (upper left, upper right, lower left, and lower right) can be applied to any discipline (and in this case, to the practice of medicine):

Orthodox or conventional medicine is a classic Upper-Right quadrant approach. It deals almost entirely with the physical organism using physical interventions: surgery, drugs, medication, and behavioral modification. Orthodox medicine believes essentially in the physical causes of physical illness, and therefore prescribes mostly physical interventions. But the Integral Model claims that every

physical event (UR) has at least 4 dimensions (the quadrants), and thus even physical illness must be looked at from all four quadrants (Wilber, 2006, p.27).

The upper-left quadrant looks at a “person’s interior states (emotions, psychological attitude, imagery, and intentions)” (p. 27). This research is interested in and driven by the lower two quadrants. Wilber (2006) explains:

The Lower-left quadrant includes all of the enormous number of *intersubjective* factors that are crucial in any human interaction - such as the shared communication between doctor and patient; the attitudes of family and friends and how they are conveyed to the patient; the acceptance (or derogation) of the particular illness (e.g. AIDS); and the very values of the culture that the illness itself threatens...The Lower-Right quadrant concerns all of those material, economic, and social factors that are almost never counted as part of the disease entity, but in fact - like every other quadrant - are *causative* in both disease and cure...The Lower-right quadrant includes factors such as economics, insurance, [and] social delivery systems... (p.27)

Looking at individual barriers to seeking treatment defines a problem in the upper quadrants, focusing on an individual’s mental or physical insufficiencies. Other studies have already explored this system (Chartrand et al., 2012; Collins et al., 2004; Gould et al, 2012; Strike et al., 2006). This paper focuses more on the barriers created by the lower quadrants - the intersubjective, social and economic factors. Rather than assuming that people with mental illness refuse to seek treatment, remember that many people do seek treatment, but encounter systemic barriers to receiving proper care. Many people who are depressed and/or suicidal do access primary health care services, but have low levels of

contact with mental health services specifically (Chartrand et al., 2012). If people admitted to hospital psychiatric units (whether voluntarily or involuntarily) have contact with some form of health service prior to the hospitalization, what are those pre-hospitalization contacts like? Are they helpful? In what ways do their services or barriers to their services influence a patient's need to be hospitalized? Rather than focus on individual reasons not to seek treatment, this research focuses on those who do actively seek help. Exploring systemic barriers to mental health care will help identify areas for improvement in our current mental health system. Again, the question is: What are the systemic barriers people with a mental health diagnosis experience accessing mental health services?

Methods

Sample

To answer the research question: What are the systemic barriers people with a mental health diagnosis experience accessing mental health services, the researcher conducted qualitative interviews with mental health clinicians from clinics and agencies in the twin cities providing services to people with a mental illness. Searching the Internet, the researcher compiled a list of eight clinics providing free or sliding scale fee mental health services. These clinicians were picked because of their close interaction with people suffering from mental illness who also have difficulty accessing care for financial and other reasons. The researcher contacted each of these clinics through e-mail and phone calls to request permission to recruit at their agency. A support letter was received from each agency and these were submitted to St. Catherine University's Institutional Review Board (IRB). The researcher asked the agencies to send out an e-

mail to their employees and/or post fliers (provided electronically by the researcher) in their agency to gather participants to interview via availability sampling. Prospective participants contacted the researcher by phone or e-mail and scheduled a mutually agreed upon interview time, at which they received information about confidentiality and consent. Participation was not limited to social workers, and could include mental health workers of varying backgrounds (psychologists, psychiatrists, therapists, interns, etc). Participants were clinicians with direct contact with clients with mental illness. Initially, the researcher wanted to interview patients currently in psychiatric hospital units to gather first hand accounts of perceived systemic barriers to mental health care. However, psychiatric patients are considered a vulnerable population, which would require a full review by St. Catherine University's IRB. Interviewing people in this population would also require the approval of a hospital's IRB (or several, if more than one hospital was selected), and the approval of family members or guardians, if certain patients are unable to give consent due to their current mental status. When the researcher contacted a hospital to find out what the IRB application process would entail, she was informed that in order to be eligible to conduct research at this hospital, she would have to be assisting or working with a clinician within the hospital. Given the short time frame of this research project, the researcher chose a sample that was more easily accessible and less vulnerable - mental health clinicians.

Protection of Human Subjects

The researcher applied to and received approval from the Institutional Review Board for project approval at St. Catherine University and completed the CITI training modules about protecting human subjects in research. As discussed earlier, those

interested in participating contacted the researcher via email or phone and received a copy of the informed consent form and interview questions at the mutually agreed upon interview time and place. At the time of the interview, the researcher reviewed the consent form and asked the participants to demonstrate verbally that they understand they were consenting to an audio taped interview in which participation is voluntary. Participants were not punished (by their employer or anyone else) if they chose not to participate (either prior to starting the interview or at anytime during the interview). Additionally, no identifying information, such as names of participants or clinics with which they are affiliated appears in the final report. All participants were 18 or older. Interviews were conducted in a private setting agreed upon by the researcher and participant, and were recorded using an audio device. Once the researcher transcribed the interviews, they were erased from the recording device. Electronic interview transcriptions were kept on the researcher's password protected personal computer.

Data Collection

Semi-structured, face-to-face interviews were conducted, guided by a set of questions (see Appendix A, excluding the first question). The questions, developed by the researcher, were mostly open-ended questions pertaining to barriers to mental health care and the relationship between access difficulties and psychiatric hospitalization. The researcher developed these questions based on personal observations and themes found in the literature review. The questions were checked with a minimum of one other peer for content validity. The researcher reserved the right to ask related, follow-up questions not listed as they came up during interviews. Interviews were expected to last about an hour

each and were recorded, transcribed, and erased from the recording device by the researcher.

Data Analysis

Transcripts were read and analyzed several times, following the content analysis method (Berg & Lune, 2012) for codes, categories, and themes. Initial notes were made in the margin, noting anything that stood out to the researcher as important. These codes were then grouped into categories and lastly into larger themes. Themes included: access difficulties leading to hospital/emergency room use, availability and accessibility issues of lack/shortage of providers and schedules/long waits, financial/insurance, and reducing and removing barriers. To test for inter-coder reliability (Monette, Sullivan, DeJong, 2011), a research peer read and analyzed the transcriptions and compared found codes, categories, and themes with the primary researcher. Having identified the themes found in the interviews, the researcher was then able to compare and contrast these themes to those found in the literature review. The researcher noted similarities and differences between themes found in the literature and themes found in the research data.

Results/Findings

Methodological Changes

The researcher originally planned to recruit mental health clinicians through twin cities agencies and conduct audio recorded face to face interviews. Several changes were made to this original plan. First, between the first committee meeting and submission to the IRB, the researcher changed her recruitment strategy slightly from going through agencies (which required agency approval letters) to directly contacting mental health clinicians through their publicly available contact information. Searching the Internet for

publicly available contact information, the researcher compiled a list of 15 clinicians providing free or sliding scale fee mental health services. These clinicians were picked because of their close interaction with people suffering from mental illness who may also have difficulty accessing care for financial and other reasons. The researcher contacted each of these clinicians at the beginning of February through e-mail and phone calls to recruit them for this study using a recruitment script approved by the IRB. Prospective participants could contact the researcher by phone or e-mail. After receiving no responses, the researcher contacted them a second time at the end of February. Only one person responded to say they did not have time to participate.

Given this information, the researcher made significant methodological changes. An amendment reflecting these changes was submitted to the IRB and approved. The decision was made to collect the qualitative data, using the identical questions originally intended for interviews, through an online Qualtrics Software survey rather than individual interviews. Finding recruiting participants through publicly available information to be unsuccessful, the researcher obtained a randomized list of e-mails of licensed clinical social workers through the Minnesota Board of Social Work. The survey was sent anonymously to the first 300 addresses in this randomized list. The survey did not collect any identifying data about the respondents. The first survey question required participants to read the informed consent form (see Appendix B) and then proceed by clicking either 'agree' or 'disagree'. The following is an overview of the results of those surveys.

Demographics

Survey responders were all licensed clinical social workers in Minnesota. To ensure anonymity, no further demographics were officially gathered. However, several responders provided some demographic information about themselves. Four different responders identified as working in rural areas. Two said they work in hospitals. One works in a federal level 3 special education middle school. The other 11 did not identify where they work. Gender demographics were not collected. Of the 18 responders, only two indicated how many years they have been working in the social work field: one for 15 years, and the other 25 years.

Overview of Findings

The Qualtrics survey was anonymously sent to a list of 300 licensed clinical social workers on March 12, 2014. Of those e-mails, 1 failed, 299 were sent, and 15 bounced. When the researcher closed the survey on March 18, 2014, 21 people agreed to the statement of consent question (first question). Due to unexplained technical difficulties, three people who agreed were not shown any of the questions beyond the consent question. There were 18 responses to the second question, 17 responses to the third, fourth, fifth, sixth, and seventh questions, 16 responses to the eighth, and 9 to the ninth question. Overall, the survey answered the question: What are the systemic barriers people with a mental health diagnosis experience accessing mental health services with the following themes.

Access difficulties leading to hospital/emergency room use. One of the survey questions asked “do you have experience with clients who have trouble accessing their therapists/psychiatrists/medication and end up going to the hospital? Please elaborate.” Seventeen people responded to this, with nine responding yes. One responder gave four

separate examples, creating a total of twelve unique yes responses. One social worker wrote, “*accessing a medical professional who will prescribe medications for a mental health condition is often a barrier for clients that I work with, often reaching to a crisis stage and then they seek out hospital help.*” Another gave several examples:

the patient cannot secure an appointment with their provider for several weeks and has a crisis so they present to the [emergency department] as instructed by their provider’s office...(or)...a patient is hospitalized in a crisis and is given a new diagnosis. After discharge they are unable to secure an appointment with and out-patient provider for weeks/months and eventually run out of the medications that were prescribed at the time of their [discharge]. Because of this, they present to the [emergency department].

Another way people present to the hospital, a respondent described, is when “*they have lost/misplaced/damaged their medications or report them stolen, and their prescribing provider will not provide additional medications until they are due for a renewal.*”

This theme was congruent with the literature’s theme of medication access and emergency service use.

Availability and accessibility of services. Echoing the literature review, a theme found in this study was that of a lack of available and/or accessible mental health providers and services. Questions six and seven referred specifically to barriers experienced by clients and the providers. Seventeen people responded to each question. Combining the responses from both questions, there were a total of forty-five references to a lack of available and/or accessible mental health providers. The researcher initially separated responses referring to availability (interpreted as “do services exist”) vs.

accessibility (interpreted as “are the available services accessible?”). However, enough responses used these terms interchangeably, that it made more sense to talk about availability and accessibility as one large theme with the following minor sub-themes: lack/shortage of providers; schedules/long waits.

Lack/shortage of providers. Of the forty-five references to availability/accessibility barriers, nine specifically mentioned a shortage of psychiatrists/medication prescribers. One respondent wrote “lack of knowledge of [patient’s] primary care physician about psych meds.” Another said “trouble with accessing psychiatry most prevalent,” and a third person wrote, “the rural aspect of the community I work in brings many challenges. There is a shortage of psych and other qualified mental health providers...”

Schedules/long waits. Another theme that arose from this research was long waits for mental health services. There were a total of eleven references to long waits. Responses included, “limited clinic hours,” “hours/availability,” and “lack of evening/weekend appointments.” One respondent said “our patients sometimes wait months to access those resources - especially psychiatry.” Another said “for psychiatric [appointments] and therapy there is usually a long waiting period to receive services up to three months because there are not enough providers.” This last response is an example of how the themes of availability and accessibility overlap. The shortage of providers translates to longer waits to get into the few providers that do exist and are taking new patients. One person commented on the lack of “availability of appointments for new clients...[and] existing clients.” A person could have ten psychiatrist offices in their area, but proximity will not do them any good if the offices are not taking new patients.

Financial/insurance. Another major theme and barrier was financial/insurance. In response to questions six and seven, there were a total of twenty three references to financial/insurance barriers. These responses included examples like “cost” (mentioned five times), “funding” (mentioned four times), “restrictive insurance coverage” (mentioned three times), “having enough money” (mentioned twice), “inadequate insurance” (mentioned twice), “health insurance - lack of or no coverage,” “little or no insurance coverage,” “insurance dictating how often/much they [patients] can see me,” “insurance gatekeepers,” “MNSure,” and “no health insurance.”

Reducing and removing barriers. Survey results identified what could be done to reduce or remove systemic barriers to mental health care. Suggestions varied but represented themes of education/advocacy, more services/providers, improving access, coordination of care, and better funding/insurance. One person wrote, “Educate, educate, educate! This leads to the destigmatization of mental illness. I do a lot of statewide training on mental illness and the commitment process. My motto is: we are all just people, after all.” Advocacy was mentioned once as “continued advocacy efforts,” and again as “increased advocacy for mental health care.” Another suggested, “more education of mental illness and on what resources are available.” Another replied, “more funding for education in schools regarding mental health, better interventions earlier.” One suggested, “better training for primary care physicians.”

Concerning the lack of providers, respondents called for “more mental health providers,” “more urgent care centers for mental health,” “provide in-home options for clients, especially children,” “train more psychiatrists,” “more child psychiatrists or physicians’ assistants with the ability to prescribe meds,” “more folks dually trained,”

and “the ability to have many mental health and substance abuse therapists available.” Related to access, people suggested, “allowing LICSWs and LPs to prescribe medication (in some states, LPs can prescribe psych meds after undergoing training),” “provide patients with transportation that adequately meets their needs,” “more accessible triage options,” “better interventions earlier,” “a more reliable way to access insurance” and “more convenient formats to visit a therapist (exp: mall office with lunch time after work [appointments]).” One person wrote, “having more school based programs would help with access to mental health services, but we are wearing thin and could use more professionals to provide services because our numbers are so high.” Another person also referenced schools, suggesting that there should be more “mental health services that are housed in schools or make rounds to schools.” One suggestion that touched on funding, education, and policy, was “continuing legislation to support CTSS school-based programs.”

Many people advocated for better funding and insurance. One person said, “funding - form of payment that would encourage agencies to provide the service.” Another wrote, “increased funding and prioritization of mental health.” “Supporting the crisis line and MCO services,” was also suggested. Responses specific to insurance included, “improve insurance coverage and reimbursement,” “improved reimbursement rates for MC and MA” “increased funding for health care insurance coverage,” and “not allowing health insurance companies to make decisions regarding treatment for primary care physicians.” One comment relating funding and the need for more providers was “pay better money so more people want to become therapists and work in rural areas.”

Discussion

There was a lot of overlap between the results and the literature review. Both this study and the literature made connections between access difficulties and hospitalization/emergency service use (Huskamp et al., 2009; Walter et al., 2006; West et al., 2010) and both identified issues with availability of and access to services (Collins et al., 2004; Chartrand et al., 2012; Galambos et al., 2004; Gould et al., 2012; Scharer, 2002; Walter et al., 2006). Many topics were referenced in both the literature and the results, but were featured more heavily in one or the other. For example, references to insurance coverage issues are found briefly in the literature review (Mościcki et al., 2010) but consistently in the research results. Integrated care was a theme in the literature review, but was only mentioned twice in the results (appearing as “better referral system,” and “more coordination of care” as suggestions to reduce or remove barriers). Both the literature and results also addressed shortages of services in rural communities (Galambos et al., 2004; Gould et al., 2012).

Differences

One theme that appeared exclusively in the literature review was “not being taken seriously.” One possibility for this theme’s absence from the results is because the research sample was clinicians rather than direct clients. The literature represents a variety of perspectives, including those of adults with mental illness (Chartrand et al., 2012; McCabe & Leas, 2008; Strike et al., 2006), family members of children with mental illness (Scharer, 2002; Walter et al., 2006), and psychiatrists (Huskamp et al., 2009; Mościcki et al., 2010; West et al., 2010), among others. The results only represent

the perspectives of licensed clinical social workers. This is one example of why future research should be done interviewing direct clients.

One theme that appeared exclusively in the results was education as a means to reduce or remove barriers. This refers to educating people with mental illness about available services, but mostly to educating the public about mental illness and health in order to reduce stigma. Stigma is a systemic barrier influencing all of the barriers explored above and could be its own separate topic. Several survey responders wrote about how education would help remove the stigma around mental illness. Educating and reducing stigma would likely increase visibility and understanding of mental illness, and draw more funding and clinicians to train.

Implications for Social Work Practice and Policy

Research results strongly communicated a need for more mental health service providers, specifically more psychiatrists or other professionals with the ability to prescribe psychiatric medication, and more services in rural areas. Current and future social workers should consider working in rural areas. They should advocate for legislative policies that create incentives for or promote the training of psychiatrists. This research challenges social workers to be aware of ways they or their agencies contribute to systemic barriers and emphasizes prevention of more intense services through earlier interventions like education, and school and community based mental health services. Social workers and other mental health professionals should seek and create positions that provide mental health urgent care, medication management, night and weekend appointments, and direct services in schools and workplaces. This research also raises awareness about the importance of coordination of care. It implies that social workers and

mental health professionals should seek and create positions that integrate physical and mental health services, which could involve better training and education of primary care physicians about mental health conditions and treatments.

Few of the above suggestions will be possible, however, without increased funding for mental health. As the research results demonstrate, funding and financial concerns were a prominent theme. Recruiting and training of psychiatrists costs money. Educating primary care physicians about mental health costs money. Conducting research costs time and money. Social workers need to advocate for increased funding for mental health so that the system can keep improving and barriers to mental health care are reduced and removed.

Recommendations for Future Research

As mentioned in the methods section, the researcher wanted to gather information about barriers to care directly from client interviews. While providers in this research gave many examples of barriers, the researcher acknowledges that providers are themselves part of the mental health system and so are removed from the first-person, client experience of systemic barriers. It is therefore recommended that future research on this topic involve subjects that are people with mental health diagnoses, specifically those who are or have been hospitalized for mental health reasons. One approach would be to interview or survey patients and/or family members of patients who are currently in a specific in-patient facility. Another approach would be to gather data from people with a history of psychiatric hospitalization, which might involve recruitment through fliers in public areas, at support groups, and mental health clinics. A third approach would be to focus on one aspect this research highlighted - the shortage of psychiatrists. Future

researchers could study why there is a shortage of these providers and what could be done to increase their numbers. The idea of education as a means to reduce barriers also provides opportunities for future research. Future researchers could evaluate programs that provide mental health education in schools and communities to find out which methods are most effective. Another good topic for future research would be to look at current funding procedures for mental health and research ways to improve this funding.

Strengths and Limitations

This research is important because it provides qualitative examples of the systemic barriers to care people with mental health issues face. This project adds to the small, but growing body of literature on this topic. The results might reduce the stigma of mental illness by looking at systemic, rather than individual barriers to care. It may illuminate barriers to providers and the public alike, helping them understand how difficult managing a mental illness is in our current system. This research can be used to inform any person working with someone with mental illness. It can inform them about barriers they may not have previously considered, and also may provide suggestions for how treatment providers can better collaborate with one another. It may also identify areas in which continued advocacy is needed for mental health care.

One limitation of this study is that people with mental illness are not being interviewed directly. The researcher was originally interested in interviewing patients in (or recently in) a psychiatric in-patient setting to get their stories of what brought them to the hospital, what resources they accessed or tried to access prior to the hospital, and their subjective experiences of the effectiveness of these services. Psychiatric patients are considered a vulnerable population. Interviewing this population would require not only a

full review by the researcher's institutional review board, but also acceptance to and approval from a hospital's institutional review board. This did not seem realistic given the short time frame to complete this project. The researcher chose instead to interview clinicians. While these interviews did not capture the direct stories of those with mental illness, they came close. Those interviewed have experience working closely with people suffering from mental illness.

Another limitation was that qualitative interviews were not conducted as originally planned. The researcher tried, unsuccessfully to contact and schedule face to face interviews with clinicians. The results found in this research were instead gathered through an electronic survey using Qualtrics Software. The same questions were used as were planned to be use in the interviews. This is both a strength and a limitation. As a strength, the researcher was still able to ask the same questions and thus get at the same content. The limitation was that several responders read questions 6 and 7 as asking the same thing, even though they were different. In a face-to-face interview, the researcher would have been able to ask clarifying and follow-up questions. Asking qualitative questions in an electronic survey also resulted in a lot of short one to two-word answers or lists, rather than detailed stories one would expect to collect through verbal interviews.

A third limitation is that, due to an expected small sample size, the results may not be generalizable to larger populations. This research project is meant to contribute to a larger discussion and evaluation of mental health services by gathering opinions of mental health professionals. Additionally, while information about barriers to mental health care originate from countries other than the U.S. (Fossey, Harvey, Mokhtari, Meadows, 2012; Knapp, Funk, Curran, Prince, Grigg, McDaid, 2006; McCabe & Leas,

2008; Strike et al., 2006), this study identifies systemic barriers to mental health care in the United States. This study in particular only surveyed licensed clinical social workers in Minnesota, although at least one respondent identified that they were dually licensed and had worked in both Minnesota and Wisconsin.

A fourth limitation directly relates to the sample and demographics. This sample was composed entirely of licensed clinical social workers, and thus did not represent the viewpoints of other mental health professionals, like psychologists, psychiatrists, licensed marriage and family therapists, or other people working directly with people with mental illness who would have insight into systemic barriers. Along with that, no demographics were gathered beyond what identifying information some responders included in their responses. We do not know the gender or ethnicity of respondents and also do not have information about how long they each have been working directly with people with mental health diagnoses or the sizes of their communities (rural vs. urban), though a few responders provided some of this information voluntarily.

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Appendix A: Survey Questions

1. Statement of Consent: you are making a decision whether or not to participate. By clicking “Agree,” you indicate that you have read and understand this information and agree to participate
2. What types of crises or issues bring clients to you and your agency?
3. What resources have clients tried before coming to you?
4. Do you have experience with clients who have trouble accessing their therapist/psychiatrist/medication and end up going to the hospital? Please elaborate.
5. What options other than hospitalization do you recommend to patients and at what point do you recommend hospitalization
6. What barriers to receiving proper mental health care do you observe or do clients directly share with you?
7. What systemic barriers have you personally encountered when assisting clients?
8. What, in your opinion, could be done to reduce or remove these barriers?
9. Is there anything else you think is important to share or comment on related to this topic?

Appendix B: Informed Consent

**Systemic Barriers to Accessing Mental Health Care: A Qualitative Study
INFORMATION AND CONSENT FORM****Introduction:**

You are invited to participate in a research study investigating what systemic barriers people with a mental health diagnosis face when accessing mental health care. This study is being conducted by Hannah Langholz, a graduate student at St. Catherine University under the supervision of Sarah Ferguson, a faculty member in the Department of social work. You were selected as a possible participant in this research because you are on the Board of Social Work's LICSW e-mail list. Please read the following information before agreeing to participate in this study.

Background Information:

Community based mental health treatment options exist, but still a significant number of people with mental illness end up in the hospital seeking psychiatric services that are, in theory, available in a cheaper, less restrictive format: outpatient care in the community. My hypothesis is that significant barriers exist on a systemic level, preventing people with mental illness from accessing needed mental health care outside of the hospital inpatient route. The purpose of this research is to identify what systemic barriers people with a mental health diagnosis experience accessing mental health services. Approximately 8 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to respond to 8 open-ended survey questions. You may write as much or as little as you like and you may choose not to answer questions. This study will take approximately 30 minutes.

Risks and Benefits of being in the study:

There are no anticipated risks and also no direct benefits to you for participating in this research.

Confidentiality:

Unless you choose to include identifying information in your responses, your responses will be anonymous. The researcher will not be able to tell who took the survey. Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one (or their affiliated agencies) will be identified or identifiable.

I will keep the research results from Qualtrics on a password protected personal computer and unless you disclose identifiable information in your responses, no one will have access to data with identifiable information. I will finish analyzing the data by May 16, 2014. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or your place of employment in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Hannah Langholz at 612-213-8424 or lang9833@stthomas.edu. If you have any additional questions later, the faculty advisor, Sarah Ferguson (651-690-6296, smferguson@stkate.edu), will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.