

Barriers to Mental Health Services: Narratives from Community Stakeholders

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Background

- ▶ Despite the existence of numerous efficacious psychosocial and pharmacological treatments for mental disorders (Wang, Demler, & Kessler, 2002) **the burden of psychiatric illness remains high.**
- ▶ 2012- an estimated **43.7 million (18.6%)** adults aged 18 or older in the U.S. had a mental disorder in the past year (SAMHSA, 2012).
- ▶ Immigrant and refugee populations, individuals from lower socioeconomic backgrounds, and men are **less likely to receive adequate mental health care** (Gonzales & Papadopoulos, 2008; Kessler et al., 2008; Snowden, 2012, Berdahl & Torres Stone, 2009).

Case Study: *September, 2015*

Worcester Community Mental Health Assessment

- ❖ Part of the Worcester Division of Public Health's (WDPH) larger, ongoing Community Health Improvement Plan (CHIP)
<http://www.worcesterma.gov/ocm/public-health/greater-worcester-chip>
- ❖ Community-based overview of:
 - ▶ **challenges** Worcester residents, providers, and Executive Directors report seeing on a daily basis
 - ▶ **different perspectives** residents hold about mental health and treatment
 - ▶ various approaches to **coping with stress** that residents demonstrate
 - ▶ **barriers and facilitators** relevant to accessing mental health services

Research Methods

Table 1. Focus Group / Interview questions for Worcester residents

1. Let's talk about the common challenges people experience on a day to day basis – that you have experienced, your family and/or friends have experienced, or that you've heard other individuals in the community have experienced, and so on.
2. You've talked about your life stressors and challenges. As you can imagine, we think that these things are deeply connected to mental health. What do you think about mental health more generally?
3. What are the different ways in which you or other individuals in your community manage these stressors?
4. What have your experiences or others' experiences that you know been with trying to access mental health services in Worcester?
5. Do you have any recommendations about the provision of services in Worcester, or services that don't exist that you'd like to see exist, or additional social assistance programs?

Table 2: Focus Group / Interview questions for Providers and Executive Directors

1. What are the most common challenges you see people experiencing in the Worcester community?
2. How do you understand consumers' and residents' ideas and attitudes towards mental health? How do you see stigma interfering with help-seeking?
3. What are the most common ways you see people coping with their life stressors and mental health challenges?
4. What are your perceptions of individuals' experiences in trying to access mental health services in Worcester?
5. What gaps do you see in the system or in your particular organization? How could service provision in the Worcester community be improved?

Research Demographics

- ▶ *Study sample:* 61 individuals in Worcester
 - Residents and/or consumers of mental health services, providers and executive directors of mental health and community-based services in Worcester.

Residents and/or consumers:

- ▶ *Participant age range:* 24 to 74 years old, **mean of 56.6.**
- ▶ *Racial and ethnic diversity:* **88%** self-identify as racial/ethnic minorities and just over **two-thirds** as U.S. immigrants.
- ▶ *Sample characteristics:* 58% men, 42% single, 77% had less than a college degree.
- ▶ *Income:* Half of the sample reporting that they earned **less than \$10,000 per year.**

Barriers to utilization of mental health services

Commonly experienced barriers in Worcester:

- ▶ Difficulties navigating the mental health system
- ▶ Non-Western notions of mental health
- ▶ Negative attitudes and stigma
- ▶ Language and cultural barriers
- ▶ Long waiting lists to see providers

Difficulties navigating the mental health system

Vietnamese resident:

- ▶ *“I have a doctor and Mass health insurance. When my doctor prescribed a medication, I took his prescription to everywhere, but no one had it. They kept telling me to go here and go there. This caused me so much stress that caused my nerves to stretch thin. I came to this place that was supposed to sell the medication, but I was sent to another place and another place. I really need help to get my medical needs met.”*

Executive director:

- ▶ *“I think a lot of the agencies are so specialized in what they do, I think sometimes they are trying to fit a square peg into a round hole...and I think organizations need to be more client-centered, and really understand the client as a unique individual...I can't tell you how many times...the therapist will say, ‘Oh, I don't work with that, you have to go here...clients are feeling abandoned, pushed-off’.”*

Non-Western notions of mental health

- ❖ Several providers noted that community residents did not always recognize symptoms of stress as psychological in nature and possibly treatable.

One mental health provider commented on culturally sanctioned belief systems:

- *“So I work with refugees and immigrants from Vietnam, so many of the individuals don’t know about mental health issues. And their mindset on it is that it’s either a demon in control of things. There’s some sort of supernatural force that’s making you act this way, see these things, hear these things or even a ghost inside you. And there are cures for it at temple ceremonies.”*

Religious pastor, in reference to experiences of trauma:

- *“They don’t know that they have trauma. It’s our responsibility to direct them to Worcester services but we have to be careful how we do it...we have to build trust with the mother and the child first.”*

Negative attitudes and stigma

- ❖ Most common for immigrants, refugee groups, military veterans

Mental health consumer:

- ▶ *“There is a lot of stigma in Worcester... Employers don’t want to hire individuals with mental illness [because] they think we’re crazies who won’t be able to do the job right.”*

Non-mental health provider:

- ▶ *“There is a lot of stigma - once they are settled - they are still in contact with each other. They feel like they have worked so hard to get to the United States that they can’t have a problem. **They can’t be looked down upon. They don’t want to get help with any of their symptoms because they don’t want to be labeled as mentally ill.**”*

Stigma for military veterans

Provider who works with military veterans:

- ▶ *“Veterans, particularly if they remain an active service member in the Guard or Reserves, are willing to tell us about their mental health issues but don’t want us to document it on their records because the military has access to their medical records. You get mixed messages from the military: on the one hand, you are encouraged to disclose your mental health condition but everything changes after that. Sometimes disclosure limits their ability for promotion and changes their career path.”*

Lack of culturally and linguistically competent care

Vietnamese resident:

- ▶ *“My difficulties are in daily activities, especially as an elder. I find that because we are an Asian, as a Vietnamese, we speak Vietnamese only and now live in American society, the most difficult is the language barrier. When you go to agencies, some do provide translation but most of them do not. So that will create obstacles when you try to communicate. Even if they have translators, it’s still difficult. But most places do not have translators.”*

Mental health provider:

- ▶ *“In some cultures, parents have a hard time - once we engage them they see it differently but care has to be done in a certain way - cultural matching helps tremendously; someone who is trained appropriately - leads to good engagement...if people don’t feel validated they don’t come back.”*

Mental health provider who works with military veterans:

- ▶ *“There are veterans who don’t want to get services in the community and prefer to be treated at the VA. The community providers don’t understand veteran culture. They feel better understood around other veterans.”*

Long waiting lists

Mental health provider:

- ▶ *“I think the most common challenge is, I think, lack of resources. When people decide - especially we see that in the public sector, psychiatry, definitely...When people decide they need services or they try to seek services, there’s a number of waiting lists, you know. And people, sometimes - especially with the Latino community, which is the community that I work with, people sometimes look for services when they really needed it yesterday, so there is a certain urgency that goes with looking at, getting the services. And, what happens is that many times there are waiting lists among the providers in town, and then either the crisis gets resolved or they have to suffer through it, end up in the hospital. You know, that I think is, access, I think is one of the biggest challenges.”*

Removing barriers to mental health services

Commonly identified needs in Worcester:

- ▶ Patient navigators
- ▶ Greater network/community among providers
- ▶ Coordinated care
- ▶ Mental health literacy education

Patient navigators

- ❖ Patient navigation can identify and target specific barriers to treatment engagement (e.g., Druss et. al., 2010).

Mental health provider who works with military veterans:

- ▶ *“I crave for my clients a patient, experienced coordinator. Someone who is comparable and analogous to an articulate, well-educated person who has the time to help navigate what might feel like a daunting, complicated, intimidating system - private or VA. People do better with someone who is in the room, who [will] help them talk to their doctor when they’re anxious about all the things that they’re dealing with - to debrief after the appointment, follow up appointments, prepare for the next appointment. The experience would be much more productive.”*

Non-mental health provider:

- ▶ *“We need more health navigators and outreach workers who are focused on specific populations like the Burmese and Vietnamese population. It’s very hard to have different people come to their homes who don’t understand their background situation. We need to include different agencies to help bridge the gap between primary care, housing and mental health.”*

Greater network/community among providers

- ▶ Desire was articulated for greater network and community among providers, both within and across agencies, e.g., the Worcester Provider Alliance
- ▶ Case studies have shown that inter-organizational networks have been linked to stronger levels of cooperation across organizations that improve cost containment without compromising the quality of patient care (Proven, 1998, 2004).

Mental health literacy

- ❖ Many people, especially recent immigrants and cultural minorities, lack knowledge of what mental illness is, how to recognize early signs, what treatments are available and how and when to seek professional help (Collier et al., 2012; Jorm, 2012).

Non-mental health provider:

- ▶ *“We need community education for those in crisis...We don’t always know how to talk about it, mental health can range from bipolar to schizophrenia to hardly presenting at all....People think that mental health treatment is for people screaming in the stress; crazy people.”*

Coordinated care

- ❖ *Linked to improvements in:* clinical outcomes, compliance with medical regimes, lower total medical costs to patients, patient and provider satisfaction, and access to behavioral health care particularly for groups that are difficult to engage (Blount, 2003).

Executive Director:

- ▶ *“What seems to be working the most smoothly for us is when behavioral health and medical work together for a patient, whether that’s an integrated or coordinated service...when we’re both on the same page, that seems to work better for patients...so, our medical providers understand what the condition of access to behavioral health is in Worcester, so they are reasonable about distinguishing between those patients in dire need for it versus those for whom it’d be helpful...and behavioral health cooperates by finding appointments for patients who are higher priority of need.”*

Summary of findings

- ▶ Worcester residents included economic challenges and elevated rates of lifetime and current exposure to violence and trauma. In addition, substance use and medical comorbidity also emerged as common themes.
- ▶ Many immigrant and refugee residents struggle with the effects of pre-immigration trauma, but are not familiar with Western notions of mental health and illness, and so focus on physical symptoms.
- ▶ Stigma emerged as a common theme across residents, providers, and Executive Directors. Of note, interviewees suggested that mental health stigma is more pronounced in immigrant and refugee populations, as well as among military veterans.
- ▶ Participants identified numerous barriers to utilizing mental health services, including long waiting lists, navigating the mental health system, language barriers, and several logistical barriers (i.e., hours of operation, transportation, and insurance copays).

Recommendations

- ▶ Greater and broader coordinated care (*increased integration of health and mental health services*)
- ▶ Increased use of case managers, patient navigators/advocates, community health workers
 - Mental health literacy/more mental health education
 - Culturally competent care
- ▶ Greater network/community among providers
- ▶ Address stigma related concerns

Closing Remarks

Pastor from local church:

- ▶ *“We need organizations that serve as a bridge to create effective communication between services. Right now there is water, and our people can’t swim. We need this bridge to be a strong bridge to connect services and get things done - a bridge that people can trust. People are accounted for and people are accountable. We have a lot of people in the community who help but don’t have the funds to do it all. We are not asking for a hand out but a hand up!”*

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Primary Authors

Esteban Cardemil, Ph.D., Clark University: Dr. Cardemil's research focuses on understanding and addressing the mental healthcare disparities in the United States that continue to disproportionately affect individuals from low-income and racial/ethnic minority backgrounds. He has been closely involved in two prior mental health needs assessments in Worcester and in Framingham that focused primarily on the Latino community.

Rosalie Torres Stone, Ph.D., Clark University and University of Massachusetts, SPARC: Dr. Torres Stone's empirical work in mental health and health disparities extends existing conceptual frameworks by including socioeconomic and culture-specific factors in examining health outcomes and access to care for underserved populations.

Kristen Keefe, M.A., Clark University: Ms. Keefe's research focuses on mental health disparities and minority mental health. She is particularly interested in better understanding disparities affecting patients' engagement in aftercare following inpatient psychiatric hospitalization.

Thank you for coming!