7-11-2019

Barriers to Mental Health Treatment in Patients Referred by Primary Care

Rebecca Palmer
rkr27f@umsl.edu

BARRIERS TO MENTAL HEALTH TREATMENT IN PATIENTS REFERRED BY PRIMARY CARE

Doctor of Nursing Practice Project Presented to the

Faculty of Graduate Studies

University of Missouri – St. Louis

In Partial Fulfillment of the Requirements

for the Degree of Doctor of Nursing Practice

by

REBECCA PALMER, BSN-RN

Allison Brauch, DNP, APRN, PMHNP-BC, NP-C, CARN-AP

Katee Thornton, MSW, LCSW

Alicia Hutchings, PHD, RN, CNE

AUGUST 2019

Abstract

Problem: Limited access to mental health treatment is one of many potential barriers to treating mental illness in the United States. Where resources are readily available, reportedly high no-show rates for established mental health appointments suggests further investigation is necessary to identify frequent barriers within that population. This was a quality improvement project to identify common themes in patient-reported barriers to care.

Methods: A 4-question phone survey was offered to individuals that did not appear at their mental health appointment. Data was analyzed to identify the most commonly reported barriers to mental health treatment. Additional data collected includes reported history of mental health treatment, and perception of referral explanation by primary care.

Results: 133 individuals met inclusion criteria, with 23 choosing to participate in the study. Transportation was the most frequently reported barrier (*n*=9), followed by the individual's perception of a poor experience with their PCP at the time of referral (*n*=6). Other reported barriers included: medical/mental health issues that prevented them from leaving the home, attitudinal reasoning, inability to take off work, forgetting about/being unaware of an appointment, financial problems, an unexpected event, and family obligations.

Implications for Practice: Despite high participation among individuals that were contacted, an excessive number of answered calls indicates that future studies may gain more valuable data if patients were contacted through other means. With transportation and poor perception of primary care as the most

frequently reported barriers, organizations should strive to educate patients on available resources and continually work to improve communication between the patient and the provider.

Barriers to Mental Health Treatment in Patients Referred by Primary Care

Mental illness is widespread and impacts approximately 44.7 million adults in the United States imposing subtle to considerable impairment on many Americans (National Institute of Mental Health [NIMH], 2017). According to the National Alliance on Mental Illness [NAMI] (2018), “Approximately 1 in 25 adults in the U.S.—9.8 million, or 4.0%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.” The impact is staggering, considering suicide is the10th leading cause of death in the US and that mental illness results in $193.2 billion in lost earnings each year (NAMI, 2018). In order to properly treat mental health disorders, we must systematically understand barriers to care.

A shortage of mental health resources presents a significant barrier to care—over half the counties in the US do not have psychiatric providers, with the number of patients seeking mental health treatment in the ED increasing by 42% over a recent 3-year period (Levine, 2018). There are also many reasons why a patient may not follow up for treatment after establishing access to a provider. Where there are mental health resources available, it is imperative that we are able to maximize the benefit and continue to improve follow up.

Primary Care Providers (PCPs) are often the initial provider contact for patients with mental health concerns. These providers will encounter diagnoses ranging from anxiety, to mood disorders, to psychosis. PCPs can prescribe a variety of psychiatric medications and provide basic counseling; however, it is important to identify patients that require further evaluation and treatment by a

mental health specialist. According to NIMH (2016), “only 10% of patients with depression receive appropriate mental health care when visiting their primary care physician.” Attention to the need for improved mental health training among medical students is growing. Warren (2017) cites a cross-sectional survey completed by the University of Colorado that included 402 randomly selected Colorado PCPs. The study found that PCPs that lack confidence in effectively diagnosing and treating mental illness may actually have less interest in participating in team-based care for their patients with mental illness, something known to improve patient outcomes. Additionally, it is difficult to build trust and fully address disorders as common as depression in a short primary care visit.

“During an illness, complex psychological, social and cultural needs disturb a patient's balance, and adversely affect his/her ability to carry out everyday activities,” (Jasemi et. al, 2017). Nursing is based on a holistic model of care, and as Advanced Practice Nurses it is important to address physical, emotional, social, and spiritual needs to achieve optimal outcomes. This theory provides a premise for determining potential areas of improvement in our ability to effectively treat the entire person. The purpose of this project is to address the mental health component within the holistic model and identify barriers to mental health treatment in adults referred by primary care within an urban county health department.

According to the county department of public health that served as a setting for this project, there were 1516 mental health appointments between November 1, 2018 and February 28, 2019. Of the 1516 appointments, 329 were

no-shows, demonstrating a no-show rate of 21.7%. The project will include a brief survey in patients that do not follow through with their mental health appointment, assessing for common themes in barriers to care.

PICO(T)

Over a 4-month period in a Midwestern, urban county health department, what are the most commonly reported barriers to mental health treatment in adults referred by primary care?

Review of the Literature

The literature review for this study includes a search of CINAHL, Google Scholar, Cochrane, EBSCO, PsycInfo, and PubMed databases. Keywords and phrases used include barriers to mental health care, mental health in primary care, mental health in the United States, Affordable Care Act and mental health care, and access to mental health treatment. Articles used were published between 2008 and 2018. This search returned 17,700 results. All articles are written in English with participants age 18 and older and identified barriers to mental health treatment. Exclusion criteria include participants under the age of 18 and articles older than 2008. 40 studies were reviewed and 15 met the inclusion criteria.

Overcoming the impact of stigma presents a critical challenge within the mental health community. There are a number of types and aspects to stigma that must be considered. People fear employment discrimination, social judgement, and the 'weakness or craziness' stereotypes. According to Heath (2017), 40% of Americans suffering from mental illness in the US go without treatment and stigma is a pressing barrier.

A potential barrier in seeking mental health treatment is the belief that treatment will not be effective. This may be due to lack of understanding of treatment goals and processes, undesirable experiences of friends or family, or a personal history of unsuccessful treatment. Goetter et. al (2018) conducted a study of barriers in patients diagnosed with generalized anxiety disorder and social anxiety disorder. The study found that over half of the sample reported

they did not believe that treatment would help with their symptoms. According to the study, it was the participants with most severe symptoms that endorsed this belief.

Considering the growth of the immigrant population over recent decades, limited English proficiency may present a challenge. In a qualitative study by Kim et. al (2011), language as a barrier was evaluated among Latino and Asian immigrants. The results of the study show these participants used mental health services less than non-Hispanic Whites. "Limited English proficiency (LEP) significantly decreased odds of mental health service use among Latino immigrants. None of the factors including LEP predicted mental health service use among Asian immigrants, who were also the least likely to access such services," (Kim et. al, (2011). Only 20% of the total immigrant group with psychiatric diagnoses participated in treatment.

Some patients may not recognize a need for mental health care and it isn't until physical symptoms become present that they consider giving their mental health the appropriate attention. Fikretoglu, Liu, Zamorski & Jetly (2016) examined perceived need for mental health care in military and civilian populations. The study identified a patient's failure to recognize the need for care as the leading barrier to accessing mental health treatment. They did find that military personnel had higher rates of recognizing the need than the civilian group, although, both groups have improved in recognizing the need since 2002.

Insurance status is a factor in accessing mental health care. Under the Affordable Care Act (ACA) many insurances are required to cover mental health

and substance abuse treatment. While many Americans remain without coverage, improvements in access to care have occurred. The uninsured rate dropped from 16% to 8.8% between 2010 and 2018, however, this leaves approximately 28.3 million Americans without insurance (Keith, 2018). According to a study by Walker et. al (2015), insurance status was the most significant indicator of access to treatment relative to other barriers. The author notes that the majority of participants did not receive mental health treatment despite insurance coverage, but that the insured are around twice as likely to access mental health treatment than the uninsured.

Transportation is often a barrier to accessing mental health care; especially for vulnerable populations. Distance, lack of car ownership, fuel costs, and inadequate public transportation contribute to the difficulty many patients find in accessing care. In a review of 6 studies by Syed, Gerber, & Sharp (2014), researchers found that 25% of patients missed a scheduled appointment because of transportation issues. Additionally, they found that 82% of participants that made their appointments had access to a car, whether it be by ownership or via friend/family member. The study points out that patients that must take the bus are twice as likely to miss appointments when compared to car users.

In some individuals, a history of negative experiences in healthcare is known to impact the drive to seek future care. A qualitative study by Taber, Leyva, & Persoskie (2014) examined why people tend to avoid medical care. The avoidance of medical care may provide insight to reasoning for avoidance of

mental health treatment. Of the 1369 participants, 33.3% reported unfavorable evaluations of physicians and healthcare organizations.

In a study by Andrade et. al (2014), low perceived need was the most commonly reported barrier, with individuals endorsing the that symptoms would resolve or improve without treatment. “Although low perceived need would be expected in mild cases, a substantial number of severe cases think that they do not need help,” (Andrade et. al, 2014). The article suggests that stigma, whether it be self-stigma or through public attitude toward mental illness may contribute to biased perceptions of need.

While demographic predictors of appointment no-shows vary by study due to differences in location and sample, demographic information will be analyzed for the purpose of this project. According to Fenger et. al (2010), younger age, less education, and being unmarried are all significant predictors. According to Vijayan (2014), incidence of no-shows analyzed by race and ethnicity suggests that non-whites are more likely to miss scheduled appointments than whites (Whites=24.2%, African Americans=41.7%, Hispanics=42.4%).

Findings in the literature reveal differences in which particular barriers are most commonly reported regard to mental health treatment. However, the same patient-reported barriers appear in the results of multiple studies. It was hypothesized that the findings of this project would produce patient-reported barriers consistent with the literature, including, transportation, lack of insurance, attitudinal reasoning, history of negative experience in healthcare, and financial barriers.

Theoretical Framework

The theoretical framework for this project is based on the Plan-Do-Study-Act (PDSA) cycle. This is a quality improvement method which predicts an effective solution to an identified problem, and includes implementation of the solution, assessment for positive or negative impact, and suggestion for change. At the end of each cycle, the quality improvement team revisits the planning phase and another cycle of improvement begins.

Once the problem was identified, the 'Plan' phase of this project was to design the study and generate lists of potential participants from the EHR. Each potential participant was contacted by phone in the 'Do' phase. In the study phase, data was analyzed and the most common barriers to mental health treatment were identified. Finally, the 'Act' phase involved presentation of the findings and recommendations for change and further study.

Method

Design

This a qualitative analysis of patient responses to a voluntary phone survey regarding barriers to mental health treatment. It is a quality improvement project meant to identify a problem, provide evidence for change, and result in recommendations to improve practice.

Setting

This study took place among three urban Midwest County Department of Public Health clinic locations. According to 2017 census information by the United States Census Bureau (USCB), the population of this Midwest County is

996,726 with 93% of the population achieving a High School Diploma or Higher and 42.4% achieving a bachelor's degree or higher. The majority of the population is white alone at 68.6%, 24.7% black alone or African American, 4.4% Asian alone, 2.1% two or more races, and 2.9% Hispanic or Latino, (USCB, 2017).

Within the county's public health department, 54.3% is female, 45.6% is male, and .01% other. The mean age is 46, with a median age of 35.6. 31.5% of this population is White, 60.5% Black/African American, 3.4% Asian, 0.3% American Indian/Alaska Native, 0.1% Native Hawaiian/Other Pacific Islander, and 4.2% is more than one race.

Sample

The population included patients that did not appear for their scheduled mental health appointment between November 1, 2018 and February 28, 2019. All individuals that met inclusion criteria on the no-show list were contacted by phone and offered participation in the survey. Inclusion criteria for the study included: English-speaking, age 18 and over, established patient of the Midwest County Department of Public Health, a mental health referral sub-form in their electronic health record, and a no show for an established appointment with a mental health provider. Exclusion criteria included: Non-English speaking patients, age 17 and younger, patients that lack a mental health referral sub-form in their electronic health record, patients that have cancelled their existing appointment, and patients with social work referrals for reasons that do not address mental health needs. In review of the literature, language was noted as

a barrier, however, it is beyond the scope of this project to include non-English speaking participants.

Approval Process

Approval was obtained by the University of Missouri St. Louis Institutional Review Board. Additional approval was obtained by the County Department of Public Health Internal Research Review Committee (IRRC). Potential benefits include an opportunity for the Health Department to make informed decisions that reduce barriers to care, an increase in treatment compliance, and improved mental health treatment rates.

Exposure of personal health information (PHI) was a risk associated with this study. Participant's name and phone number was used only for contact purposes. Patient charts were searched by name and date of birth, and the following information was accessed in chart: race, gender, insurance status, and reason for referral. A coded document was created to link patient responses to a number rather than a name. The master list containing personal health information was contained in a password secured Excel document to protect confidentiality and destroyed upon the completion of the study. All personal information was deidentified for data analysis.

The second potential risk was emotional distress experienced by the individual, due to thoughts or discussion surrounding the referral or their inability to make their appointment. In the occurrence of this unlikely event, the phone number for the health department would be provided if the patient wished to reopen the referral and reschedule. For any patient experiencing a mental health

crisis, the Behavioral health Response crisis line phone number would be provided.

Data Collection/Analysis

At the public health department, referrals for mental health services can be made via the following channels: Social Services, Behavioral Health Consultants, Psychiatry, and Substance Abuse Services. All charts on the no-show list were reviewed to ensure the referral was for mental health, as opposed to community resource assistance. Demographic information including, race, gender, age, military status, and insurance status were recorded directly into the secured Excel document.

Data related to barriers to care were collected through self-report during a phone interview, and variables measured include: transportation, lack of insurance, the inability to miss work, attitudinal reasoning, stigma, history of mental health treatment, and perception of explanation provided by the PCP at the time of the referral.

Procedure

A no-show list for mental health appointments was pulled from the Electronic Health Record. The list included no-shows that occurred between November 1, 2018 and February 28, 2019. Patients that met inclusion criteria were contacted by phone for a 4-item survey (Appendix A). Two attempts were made to contact each potential participant. Charts were reviewed to obtain demographic data and reason for referral, at which time that information was directly entered into the data collection tool. The data collection tool and master

list were kept in password protected Excel spreadsheets on a laptop owned by the private investigator.

Results

Between November 1, 2018 and February 28, 2019, 329 no-shows for mental health appointments occurred among 228 individual patients. Of those 228 patients, 133 met inclusion criteria for the study. Of the 133 potential participants that were contacted for the phone survey: 86 individuals did not answer the call,13 declined to participate, 4 had incorrect phone numbers recorded in the EHR, 7 phone numbers were disconnected, and 23 agreed to participate in the survey (Appendix B).

Among the participants (*n*=23), the male to female ratio was 5:18 (participant demographics presented in Appendix C). African Americans made up 78% of the participants (*n*=18), and Caucasians accounted for the remaining 22% (*n*=5). The majority of the individuals were insured (*n*=18); 52% with Medicaid (*n*=12), 13% with private insurance (*n*=3), and 22% remain without insurance (*n*=5). 13% reported being covered under Gateway to Better Health (*n*=3). None of the participants were current or previous military members. 87% of the individuals had been treated for mental health concerns in the past (*n*=20), and 52% (*n*=12) did not feel the referral was fully explained to them by their PCP at the time the referral was made.

The most frequently reported barrier to appearing for the scheduled mental health appointment was transportation 31% (*n*=9). The second most frequent barrier reported was the individual’s perception of a poor experience

with their PCP at the time of referral 21% (*n*=6).14% of participants reported medical or mental health issues prevented them from leaving the house at the time of the appointment (*n*=4), and 7% of participants did not believe they needed treatment (*n*=2). Additional barriers reported included: Inability to take off work 4% (*n*=1), forgot about the appointment 3% (*n*=1), unaware an appointment was made 3% (*n*=1), financial problems 7% (*n*=2), an unexpected event 7% (*n*=2), and family obligations 3% (*n*=1). This data is presented in Appendix D.

Discussion

It is difficult to generalize these findings in larger populations based on the volume of data collected by use of the phone survey. The data suggests transportation is a significant barrier to care, which is consistently supported in the literature. Participants reported they had arranged rides that never arrived to pick them up, the appointment location was too far, or they did not have money for gas or bus fare. With telehealth gaining momentum, and an additional 14% (*n*=4) of individuals reporting they could not leave their home due to medical conditions, it may be worth assessing for access to the Internet for telepsych visits to address transportation and health barriers in the future. According to the American Psychiatric Association (2017), “Telepsychiatry — in the form of live interactive videoconferencing — has become a core tool of daily clinical practice.”

Poor communication among PCPs and patients was the second most frequently reported barrier. The findings in this study suggest that improving the experience at primary care appointments may decrease the number of no-shows

in mental health. Participants that reported a poor experience with primary care as a barrier expressed feelings that their PCP was not attentive to their personal goals or wants, or they didn't feel that the provider cared about their physical and mental health concerns. Additionally, over half of the participants didn't feel that the referral was properly explained to them. It was reported that there was difficulty understanding medical terminology when the PCP provided explanations, and at times the provider would indicate that they are making several referrals without explaining each referral individually.

With 65% of phone calls to potential participants going unanswered, the data suggests a higher volume of information may be obtained through a different means. Technology has allowed those with a cell phone to access caller ID, and it is possible that a large portion of data was excluded from this study because many people do not answer calls from phone numbers they do not recognize. According to Paul (2019), more than half (52%) of phone calls per year go unanswered by Americans. Allowing patients to complete a survey that identifies barriers to mental health treatment at their primary care appointments may result in more useful data.

It is worth noting that 22% (*n*=72) of the 329 no-shows were immediately excluded from the study because there was no referral sub-form completed in the EHR, making data collection even more difficult. This sub-form is a specific electronic referral form in an EHR that includes situation specific information and is sent directly to the mailbox of the specialist. Use of the sub-form is a procedure that ensures the referral reaches the correct specialist, allows the investigator to

determine who made the referral and why, and can be useful in continuity of care for providers. This results in referrals made through an ad hoc process, which may impact future quality improvement studies. Measures taken to increase usage of sub-forms would allow for more accurate data going forward.

Conclusion

The findings in this study indicate transportation and a reported poor experience with primary care are the most commonly reported barriers to mental health treatment within a Midwest, urban county health department. Future studies should consider data collection through in-person interviews, surveys completed at primary care appointments, or surveys distributed by email, to obtain a higher volume of data than was collected through phone call attempts. Transportation and a poor experience with primary care account for over half of the reported barriers to mental health treatment. According to the data provided in this study, ensuring adequate education on available transportation resources and improving communication in primary care may decrease the number of missed mental health appointments.

References

American Psychiatric Association (2017). How do you train for telepsychiatry? Retrieved from https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/how-do-you-train-for-telepsychiatry

Andrade, L., Alonso, J., Mneimneh, Z, Wells, J., Al-Hamzawi, A., Borges, G, & Fenger, M. (2014). Barriers to mental health treatment: Results from the WHO World Mental Health (WMH) Surveys. *Psychol Med, 44*(6). doi: 10.1017/S0033291713001943

Fikretoglu, D., Liu, A., Zamorski, M., & Jetly, R. (2016). Perceived need for and perceived sufficiency of mental health care in the Canadian Armed Forces. *The Canadian Journal of Psychiatry.* http://dx.doi.org.ezproxy.umsl.edu/10.1037/ser0000254

Goetter, E., Frumkin, M., Palitz, S., Michaela, S., Baker, A., Eric, B., & Momi, S. (2018). Barriers to mental health treatment among individuals with social anxiety disorder and generalized anxiety disorder. *Psychological Services*. http://dx.doi.org.ezproxy.umsl.edu/10.1037/ser0000254

Heath, S. (2017) Understanding Stigma as a Mental Healthcare Barrier Retrieved from https://patientengagementhit.com/news/understanding-stigma-as-a-mental-healthcare-barrier?utm_content=b1281c3eaa9e820f79ecee0fe1311937&utm_campaign=MHD%25206%252F8%252F17&utm_source=Robly.com&utm_medi

Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A concept of holistic care by Hybrid Model. *Indian J Palliat Care, 23*(1), 71-80.

Keith, K. (2018). Two new federal surveys show stable uninsured rate. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180913.896261/full/

Kim, G., Aguado, L., Chariboga, D., Jang, Y, Parmelee, P., & Allen, R. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research, 45*(1), 104-110. https://doi.org/10.1016/j.jpsychires.2010.04.031

Levine, D. (2018). What's the answer to the shortage of mental health providers? Retrieved from https://health.usnews.com/health-care/patient-advice/articles/2018-05-25/whats-the-answer-to-the-shortage-of-mental-health-care-providers

Mitchell, G. (2013). Selecting the best theory to implement planned change. Retrieved from http://home.nwciowa.edu/publicdownload/Nursing%20Department%5CNUR310%5CSelecting%20the%20Best%20Theory%20to%20Implement%20Planned%20Change.pdf

Mortensen, E., Polson, S., & Lou, M. (2010). No-shows, drop-outs and completers in psychotherapeutic treatment: Demographic and clinical predictors in a large sample of non-psychotic patients. *Nord J Psychiatry, 65*(3). doi: 10.3109/08039488.2010.515687

National Alliance on Mental Illness (2018). Mental health by the numbers. Retrieved from https://www.nami.org/learn-more/mental-health-by-the-numbers

National Institute of Mental Health (2016). Adding better mental health care to primary care. Retrieved from https://www.nimh.nih.gov/news/science-news/2016/adding-better-mental-health-care-to-primary-care.shtml

National Institute of Mental Health (2017). Mental illness. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Paul, K. (2019). As the FCC votes on letting consumers block robocalls—here's how else you can stop them. Retrieved from https://www.marketwatch.com/story/why-more-than-half-of-americans-wont-answer-the-phone-2019-01-31

Sayed, S., Gerber, B., & Sharp, L. (2014). Traveling towards disease: Transportation barriers to health care Access. *J Community Health, 38*(5), 976-993. doi: 10.1007/s10900-013-9681-1

Taber, J., Leyva, B., & Persoskie, A. (2015). Why do people avoid medical care? A qualitative study using national data. *J Gen Intern Med, 30*(3), 290-297. doi: 10.1007/s11606-014-3089-1

United States Census Bureau (2017). QuickFacts St. Louis County Missouri. Retrieved from https://www.census.gov/quickfacts/stlouiscountymissouri

Vijayan, M. (2014). No shows: Effectiveness of termination policy and review of best practices. Retrieved from

https://corescholar.libraries.wright.edu/cgi/viewcontent.cgi?article=1117&context=mph

Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2015). Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric services (Washington, D.C.)*, *66*(6), 578-84.

Warren., A. (2017). Team-based care for patients with mental illness is linked to PCP confidence level. Retrieved from https://www.mdmag.com/medical-news/teambased-care-for-patients-with-mental-illness-in-linked-to-pcps-confidence-

Appendix A

Phone Survey

Code # ____

You have been read a full consent and your responses to the survey indicate your informed consent.

1. What prevented you from making it to your appointment? Select all that apply.
    a. Transportation: How do you usually get to scheduled appointments?
        1) Public Transportation
        2) Personal Vehicle
        3) Friend/Family member
        4) Walk
        5) Other:_____
    b. Lack of insurance
    c. Unable to take off work
    d. Lack of childcare
    e. Stereotypes/Stigma associated with mental health treatment
    f. I forgot about the appointment
    g. Attitudinal Reasoning
        1) I do not believe the mental health referral was necessary
        2) Personal history of unsuccessful treatment
        3) Family/friend reported unsuccessful history
    h. Other: _____

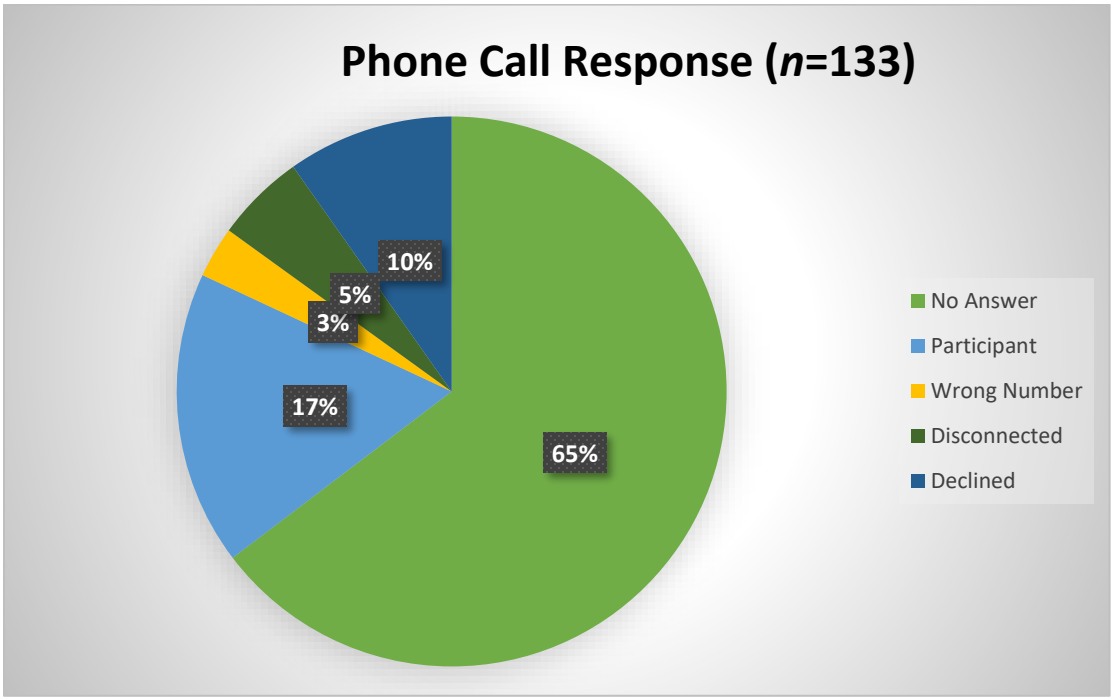
2. Have you been treated for any mental health related concerns in the past?
    a. Yes
    b. No

3. Have you ever been in the military?
    a. Yes
    b. No

4. Do you feel like your primary doctor fully explained this referral to you?
    a. Yes
    b. No
        i. In the future, what information would you like your primary doctor to better explain when making a mental health referral?

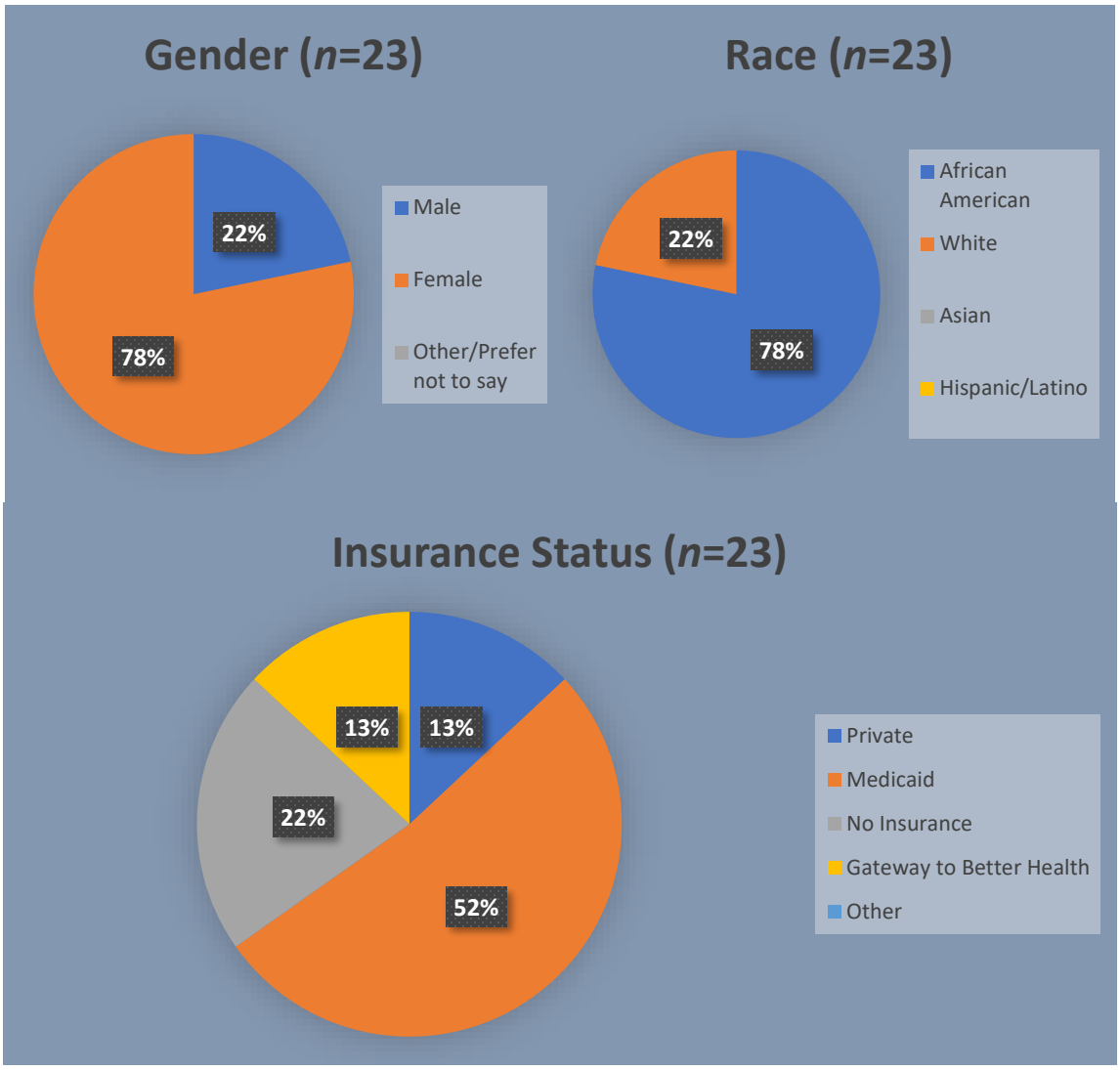
Appendix B

Response to Phone Calls Made to Potential Participants



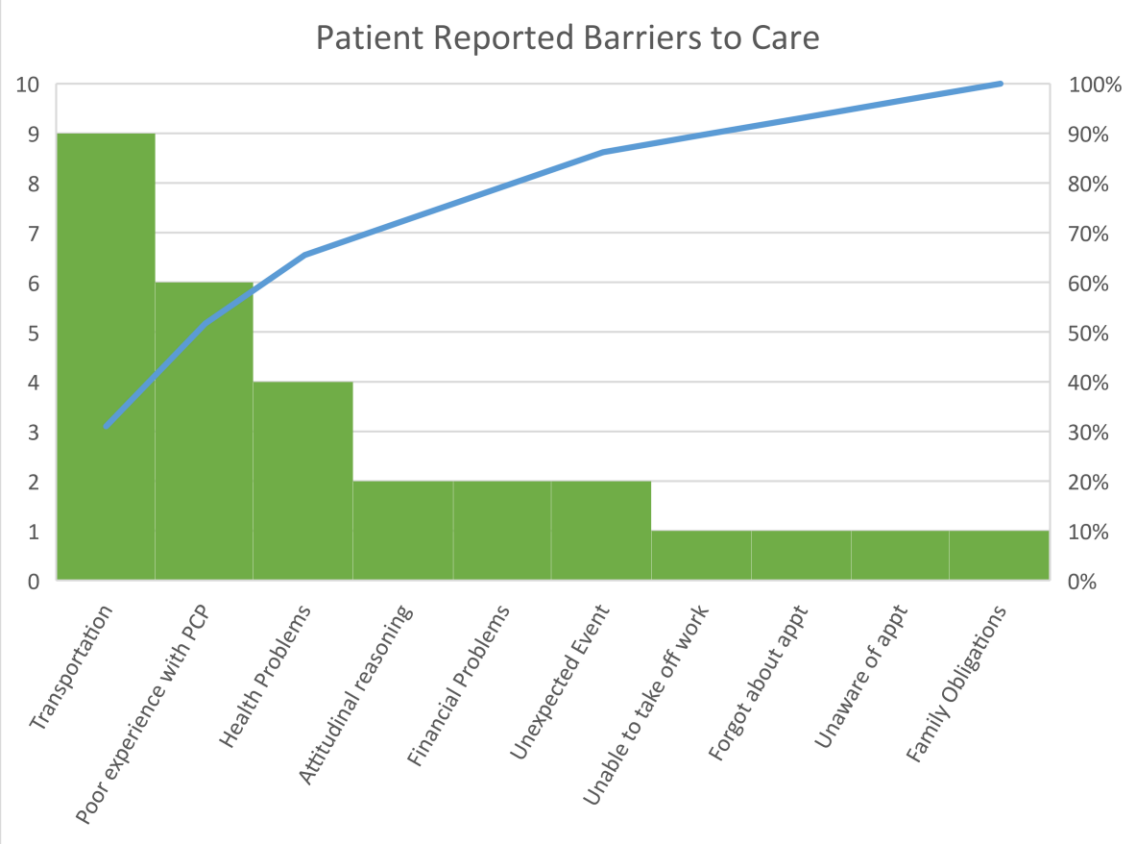
Appendix C

Participant Demographics (*n*=23)



Appendix D

Participant Response: Patient Reported Barriers to Care



Appendix E

Participant Response: Perception of Referral Explanation by PCP (*n*=23)