*Epidemiology and Psychiatric Sciences*

**cambridge.org/eps**

# I treat mental illness every day, yet I cannot find mental health treatment when I need it

Marcela Almeida

Harvard Medical School, Boston, Massachusetts 02115, USA and Cambridge Health Alliance, Cambridge, MA 02139, USA

## Editorial

**Cite this article:** Almeida M (2021). I treat mental illness every day, yet I cannot find mental health treatment when I need it. *Epidemiology and Psychiatric Sciences* **30**, e2, 1–3. https://doi.org/10.1017/S2045796020001092

Received: 22 October 2020
Revised: 5 November 2020
Accepted: 11 November 2020

**Author for correspondence:**
Marcela Almeida,
E-mail: maralmeida@cha.harvard.edu

© The Author(s), 2021. Published by Cambridge University Press. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike licence (http://creativecommons.org/licenses/by-nc-sa/4.0), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the same Creative Commons licence is used to distribute the re-used or adapted article and the original article is properly cited. The written permission of Cambridge University Press must be obtained prior to any commercial use.

CAMBRIDGE
UNIVERSITY PRESS

At the end of a long work day, I checked my messages, my eyes dazzling in excitement at one of them in particular. 'I'm ready. Can you find me a psychiatrist'? An old friend had been contemplating getting mental health treatment for quite some time, but along the way, there were stigma, cultural misperceptions, and hope that his symptoms would resolve on their own. I received his request with exhilaration and relief, knowing how much it would benefit him and his family. I work as a psychiatrist for a large and prestigious organization in the Boston area and was certain that in no time my friend would be connected with a great clinician and would soon feel a lot better. That certainty quickly became astonishment at the sad realization that his reluctance to get help was not the most significant obstacle: help simply was not available.

The old adage 'Help Is a Phone Call Away' does not apply to psychiatric care. In this case, help was countless emails, text messages and phone calls away – first to close friends, then not-so-close friends, colleagues, acquaintances and then random people recommended by all of the above. From ridiculously long waitlists to practices not taking new patients, or clinicians who had to cut back their hours to accommodate their increased childcare responsibilities due to the pandemic, my friend remained untreated and I, perplexed.

Having worked with underserved populations most of my adult life, I was well aware of the scarcity of resources and limitations of access to healthcare. I knew that, frequently, one's zip code is a more important health determinant than one's genetic code. From my upbringing in Latin America, I knew, for example, that about three-quarters of people with serious mental illness in less-developed countries do not receive treatment (Demyttenaere *et al*., 2004). I vividly remember patients' reports that they had to cut their pills in half so that they would last until their next visit with the doctor, only to decompensate in the interim. Sadly, I also lived through similar statistics and experiences while practising psychiatry on the South Side of Chicago.

Never would I have imagined, however, that this highly educated, wealthy, well-connected, white man would face any barriers in Boston, Massachusetts, a medical oasis with some of the best hospitals and doctors in the world and a ridiculous abundance of medical schools and training programs. Intrigued, I proceeded to investigate the reasons behind it. In this particular situation, we faced an unfortunate combination of clinicians who were instantly overloaded by the growing demand for psychiatric care incurred from the pandemic and doctors who had to reduce their clinical hours in order to accommodate eldercare or childcare needs after the closures of schools and daycare centres, all superimposed to the underlying chronic shortage of psychiatrists and some other network regulations that dictate where one may receive specialised care based on the location of their primary care provider.

According to Mental Health America, the nation's leading community-based advocate for those living with mental illness, more than half of adults with a mental illness receives no treatment, a number that has merely improved in the past decade (https://www.mhanational.org/). States are ranked based on a complex algorithm that includes access to insurance and treatment, special education and workforce availability. Ironically, in their current edition, Massachusetts ranks first, meaning it has the highest rates of access to care and availability of mental health providers nationwide. Mental health workforce ranged from 180:1 in Massachusetts to 1100:1 in Alabama. Prevalence of untreated adults with mental illness ranged from 41.4% in Massachusetts to 66.0% in Nevada.

The global impact of mental illness has been well-studied. We now know that mental illness constitutes an estimated 7.4% of the world's measurable burden of disease (Becker and Kleinman, 2013). It causes more economic burden, for example, than each of four other major categories of noncommunicable disease: diabetes, cardiovascular diseases, chronic respiratory diseases and cancer (Bloom *et al*., 2011; Chen *et al*., 2018). Major depression alone represents the second leading cause of years lost to disability (Becker and Kleinman, 2013) and is expected to be the largest contributor by 2030 (WHO, 2004; Franklin *et al*., 2019).

Nevertheless, resources remain scarce and difficult to access, and the financial allocation for mental health care continues to shrink. The United States Department of Health and Human Services' fiscal year 2020 Budget Request for substance abuse and mental health is $5.68 billion, a decrease of $65 million from last year. The budget request for next year is $5.74 billion,

a decrease of $142 million from this year (Department of Health and Human Services, 2020). The situation is worse in low-income countries, some dispensing a meagre 0.5% of the total health budget to mental health (Hock *et al*., 2012).

Approximately 20% of adults struggle with mental illness annually in the USA, the equivalent to 43.4 million Americans. Suicidal ideation and suicide rates are increasing. Between 2001 and 2017, the total suicide rate increased by 31% from 10.7 to 14.0 per 100 000. In 2017 alone, it claimed the lives of 47 000 people. Suicide was the second leading cause of death among individuals between the ages of 10 and 34 (Center for Disease Control and Prevention, 2018) and more than half of suicidal patients do not receive mental health services.

Among the youth, the numbers are equally alarming. Between 13% and 20% of children in the USA have a mental, emotional or behavioural disorder each year and, while the prevalence continues to rise, access to treatment remains challenging, particularly among Blacks, Hispanics and children raised by a single parent. Between the ages of 12 and 17, the prevalence of a major depressive episode within the past year increased from 8.66% to 13%, 60% of whom did not receive any mental health treatment, even in states with the greatest access. That is more than two million youth with a major mental illness who do not receive psychiatric treatment.

Currently, only about one-quarter of the nation's mental health provider needs are met. Barriers to mental health treatment include:

- Lack of insurance, limited coverage or insufficient finances to cover costs including copays, uncovered treatment types or when providers do not take insurance (Mojtabai, 2005). In the USA, financial barriers to mental health treatment have increased over the past decade. Despite The Mental Health Parity and Addiction Equity law, enacted a decade ago and promising equal coverage of mental health and substance use services, there is still a significant number of people with private insurance that does not cover psychiatric conditions. The proportion of youth with private insurance that does not cover mental or emotional difficulties nearly doubled, from 4.6% in 2012 to 8.1% in 2017 (Piscopo *et al*., 2016).
- Shortfall in psychiatrists and an overall undersized mental health workforce: The Health Resources and Services Administration (HRSA) projects a substantial shortage of mental health and substance use treatment providers to meet the demand in 2030, which translates into high burnout rates among clinicians and long waits for necessary treatment. The nation needs just over 7000 more mental health clinicians to fill the provider shortage. In Alabama, for example, there is one mental health provider per 1260 people (Mental Health America, 2020)
- Lack of available treatment types (inpatient treatment, individual therapy, intensive community services): Nearly half of Americans have had to or know someone who has had to drive more than an hour roundtrip to seek treatment. Telehealth has remained vastly underused as an option for treating mental health issues, with only 7% reporting ever using it. In Massachusetts, there are approximately 100 patients waiting for a psychiatric bed on a typical day. On average, patients with physical health issues waited 4.2 h for a bed, while mental health patients waited 16.5 h. To be transferred to another facility, physical health patients had an average wait of 3.9 h, while mental health patients had to wait for about 21.5 h. These wait times are longer if you are uninsured or on Medicaid (Pearlmutter *et al*., 2017; Mental Health America, 2020).
- Disconnect between primary care systems and behavioural health systems. Approximately one-third of Americans did not get psychiatric help due to not knowing where to get services. Among immigrants, the numbers are scarier. Immigrants receive mental health treatment at much lower rates compared to American born persons, despite equal or, more likely, greater needs. One study of Asian and Latino immigrants found that only 6% of immigrants had ever received mental health care, making them 40% less likely than US-born participants to access services (Lee and Matejkowski, 2012; Derr, 2016). Many turn to family, religious leaders and friends first, delaying treatment with mental health professionals or physicians.

The COVID-19 pandemic made the demand for psychiatric services even higher. Unpredictability and uncertainty, lockdown and social isolation, financial stress, loneliness, inactivity, increased use of alcohol and other drugs, and limited access to basic services, all contribute to the onset or worsening of mental health issues (Pfefferbaum and North, 2020), but also urged the development of creative solutions to alleviate people's suffering (Patel and Saxena, 2014; Saloner *et al*., 2018). As a consequence, many rules governing remote treatment had to be instantly relaxed. Medications can now be prescribed over the phone and psychotherapy sessions and groups can be held virtually, even when patient and clinician are in different states. Hopefully, this crisis *du jour* will serve to reaffirm the serious impact of mental illness in numerous segments of society and to expose the chronic limitations to access care. The implementation and expansion of life-saving treatment options may hopefully persist after the pandemic, a welcomed and much-awaited silver lining.

**Acknowledgments.** The author would like to acknowledge Dr. Jacob Venter, MD, MBA, a fierce advocate for the expansion of mental health access in Massachusetts.

## References

**Becker AE and Kleinman A** (2013) Mental health and the global agenda. *New England Journal of Medicine* **369**, 66–73.

**Bloom DE, Cafiero E, Jané-Llopis E, Abrahams-Gessel S, Bloom L and Fathima S** (2011) *The Global Economic Burden of Noncommunicable Diseases*. Geneva, Switzerland: World Economic Forum.

**Chen S, Kuhn M, Prettner K and Bloom DE** (2018) The macroeconomic burden of noncommunicable diseases in the United States: estimates and projections. *PLoS One* **13**, e0206702, Published 2018 Nov 1.

**Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kovess V, Lepine JP, Angermeyer MC, Bernert S, de Girolamo G, Morosini P, Polidori G, Kikkawa T, Kawakami N, Ono Y, Takeshima T, Uda H, Karam EG, Fayyad JA, Karam AN, Mneimneh ZN, Medina-Mora ME, Borges G, Lara C, de Graaf R, Ormel J, Gureje O, Shen Y, Huang Y, Zhang M, Alonso J, Haro JM, Vilagut G, Bromet EJ, Gluzman S, Webb C, Kessler RC, Merikangas KR, Anthony JC, Von Korff MR, Wang PS, Brugha TS, Aguilar-Gaxiola S, Lee S, Heeringa S, Pennell BE, Zaslavsky AM, Ustun TB and Chatterji S** (2004) WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association* **291**, 2581–2590.

**Department of Health and Human Services** (2020) *Substance Abuse and Mental Health Services Administration*. Rockville, Maryland: U.S.

Department of Health & Human Services, Washington, D.C. and Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. Available at https://www.samhsa.gov/sites/default/files/about_us/budget/fy-2021-samhsa-cj.pdf.

**Derr AS** (2016) Mental health service use among immigrants in the United States: a systematic review. *Psychiatric Services* **67**, 265–274.

**Franklin M, Mukuria C, Mulhern B, Tran I, Brazier J and Watson S** (2019) Measuring the burden of schizophrenia using clinician and patient-reported measures: an exploratory analysis of construct validity. *The Patient* **12**, 405–417.

**Hock RS, Or F, Kolappa K, Burkey MD, Surkan PJ and Eaton WW** (2012) A new resolution for global mental health. *Lancet (London, England)* **379**, 1367–1368.

**Leading Causes of Death Reports** (1981–2018) Centers for Disease Control and Prevention Available at https://webappa.cdc.gov/sasweb/ncipc/leadcause.html. Accessed 2018.

**Lee S and Matejkowski J** (2012) Mental health service utilization among noncitizens in the United States: findings from the National Latino and Asian American Study. *Administration and Policy in Mental Health* **39**, 406–418.

**Mental Health America** (2020) Available at https://www.mhanational.org/issues/state-mental-health-america Accessed October 30, 2020.

**Mojtabai R** (2005) Trends in contacts with mental health professionals and cost barriers to mental health care among adults with significant psychological distress in the United States: 1997–2002. *American Journal of Public Health* **95**, 2009–2014.

**Patel V and Saxena S** (2014) Transforming lives, enhancing communities--innovations in global mental health. *New England Journal of Medicine* **370**, 498–501.

**Pearlmutter MD, Dwyer KH, Burke LG, Rathlev N, Maranda L and Volturo G** (2017) Analysis of emergency department length of stay for mental health patients at Ten Massachusetts Emergency Departments. *Annals of Emergency Medicine* **70**, 193–202.e16.

**Pfefferbaum B and North CS** (2020) Mental health and the covid-19 pandemic. *New England Journal of Medicine* **383**, 510–512. Epub 2020 Apr 13.

**Piscopo K, Lipari RN, Cooney J and Glasheen C** (2016) *Suicidal Thoughts and Behavior among Adults: Results From the 2015 National Survey on Drug Use and Health*. National Survey on Drug Use and Health (NSDUH) Data Review, Available at http://www.samhsa.gov/data. Accessed September, 2016.

**Saloner B, McGinty EE, Beletsky L, Bluthenthal R, Beyrer C, Botticelli M and Sherman SG** (2018) A public health strategy for the opioid crisis. *Public Health Reports* **133**, 24S–34S. PMID: 30426871; PMCID: PMC6243441.

**World Health Organization** (2004) *WHO Global Burden of Disease: 2004 Update*. Geneva: World Health Organization; 2008. [accessed Feb 5, 2012]. Available at http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf.