Research Summary: Behavioral Health Care Barriers

United States of Care and Third Horizon Strategies

November 2021

About United States of Care

United States of Care (USofCare) is a nonpartisan organization committed to ensuring that everyone has access to quality, affordable health care. The organization aims to drive a unique cross-sector, people-centered approach to prioritizing, creating, and advancing state and federal policies that meet the needs of people and result in a more equitable health care system.

About Third Horizon Strategies

USofCare partnered with Third Horizon Strategies (THS) Behavioral Health Team for this Research Summary.

THS is a boutique, strategic health care advisory firm focused on shaping a future system that actualizes a sustainable culture of health nationwide. The firm offers a 360° view of complex challenges across three horizons – past, present, and future – to help industry leaders and policymakers interpret signals and trends; design integrated systems; and enact changes so that all communities, families, and individuals can thrive.

Virtual care as a solution to **addressing barriers** people experience in **accessing** care and **reducing disparities**

The Issue: We know that people face barriers to accessing health care that meets their unique needs.

USofCare's Work – Closing gaps in access through virtual care: COVID-19 is unleashing a revolutionary expansion in virtual care. Without careful attention, these changes may leave people and communities behind who already face barriers accessing care. We are:

- ★ Leveraging our listening research to understand people's diverse experiences with virtual care
- ★ Identifying, developing and sharing policies and approaches that reflect people's priorities and close gaps in access

**Learn more about USofCare's virtual care work at http://unitedstatesofcare.org/priority/virtual-care/*

Virtual Care in the Behavioral Health Care Setting: Overcoming Barriers to Care

To answer the question: ***"To what extent can virtual care be used as a tool to address inequities in access to treatment for mental health and substance use disorders?"*** we must first understand the barriers to care that are contributing to the inequities.

What follows is a summary of the research on barriers patients and providers experience when accessing behavioral health care services. The barriers identified in this brief were curated through publicly available research with the guidance of industry experts.

Barriers to care do not impact all populations the same way. In fact, barriers can be mitigated or exacerbated based on demographics, including race, ethnicity, age, gender, geographical region, and socioeconomic factors. Barriers may also be heightened by clinical condition or acuity.

Underserved populations, like people of color and people living in rural areas, are disproportionately impacted by barriers to behavioral health care.

Learn more about our research on barriers to virtual care in behavioral health and policy considerations to address these inequities here.

Patient Access Barriers

UNITED STATES of CARE

Challenges that inhibit *people* from seeking or accessing needed behavioral health services:

- **Stigma** associated with behavioral health conditions
- **Cost** to receive ongoing care
- **Coverage** limitations or lack of coverage
- **Long wait times** to get an appointment
- **Cultural and linguistic** challenges
- **Fear of repercussions** for seeking treatment or support
- **Social factors**, such as food, housing, and transportation insecurity

Barrier to Behavioral Health: **Stigma**

Definition: A discriminatory or negative prejudice toward behavioral health that either comes from oneself, peers, or institutions.

Research-Based Evidence:

- 51% of respondents surveyed were comfortable talking about mental health at their job, while 38% of individuals surveyed were not. One main concern from those who did not feel comfortable was the fear of negative consequences from their employer
- 47% of respondents surveyed said that they "worry that others judge them when they say they've sought mental health services." 34% admit that they have lied about receiving services

Disparity Impact:

- Rural residents: Stigma and confidentiality concerns may be exacerbated for rural residents seeking treatment for SUD because of a lack of anonymity in small communities where there are few mental health providers
- Young men: Younger men were more likely to be uncomfortable about retaliation from an employer
- Latino community: Many members of the Latino community believe that Opioid Use Disorder (OUD) is a moral failing and not a fixable, chronic condition
- Older black adults: Older Black adults believed that mental health issues were an individual's problem and sign of weakness
- LGBTQ people of color: LGBTQ people of color highlight that stigma was a big barrier to mental health care. They used words like "ashamed," "weakness," and "embarrassed" to describe why they did not seek mental health care

Barrier to Behavioral Health: **Cost**

Definition: Behavioral health care is either inaccessible or made difficult by an inability to afford care.

Research-Based Evidence:

- 58% of respondents surveyed said that cost of care was a *very important* factor
- 34% of respondents surveyed said that cost or poor insurance coverage was the biggest barrier in seeking effective mental health services
  - 25% of respondents had to choose between paying for daily necessities and getting mental health treatment
  - 20% of respondents have chosen between physical and mental health because of cost
  - 60% of respondents indicated that making mental health services more affordable would be "extremely effective" at improving access and quality
- Cost is the most reported barrier to using mental health by adults with any mental illness who had an unmet need for services. The cost barrier was almost twice as common as the next most reported barrier
- 44% of adults with any mental illness (AMI) and 52% of adults with serious mental illness (SMI) cited not receiving services despite having a mental illness or a perceived unmet need for mental health services because they could not afford the cost of care

Barrier to Behavioral Health: **Cost** (cont.)

Research-Based Evidence:

- Respondents reported higher out-of-pocket costs, such as co-pays, for outpatient mental health services than for other types of medical care, reflecting disparities in accessing mental health care relative to primary care and specialty care. Out-of-pocket costs exceeding $200 were more frequent for visits to mental health therapists (15%) and psychiatric prescribers (16%) compared to medical specialty care (9%)
- 21% of people aged 12 or older with a past year SUD who did not receive treatment at a specialty facility and had perceived a need for treatment cited having no health care coverage and not being able to afford the cost of treatment, the most common reasons cited
- 29% of adults with a cognitive disability were not able to see a doctor due to costs

Disparity Impact:

- LGBTQ youth: 53% of LGBTQ youth cited inability to afford mental health as the biggest barrier to care

Barrier to Behavioral Health: **Coverage**

Definition: Behavioral health care is either inaccessible or made difficult by lacking or limited insurance.

Research-Based Evidence:

- 58% of respondents said that coverage was a *very important* factor
- 34% of respondents said that cost or poor insurance coverage was the biggest barrier in seeking effective mental health services
  - 40% wished their insurance plan covered mental health appointments
- Only 43% of psychiatrists across the U.S. accepted Medicaid (between 2005-2010), while 73% of all other providers did
- 11% (over 5.1 million) of adults with a mental illness remain uninsured
- Patients with behavioral health conditions were more likely than those with physical health problems to end up seeing out-of-network physicians
  - People with drug use disorders were 13 percentage points more likely to receive out of network inpatient care than people with chronic heart failure and 15 percentage points more likely to receive out of network outpatient care
- Behavioral health and medical/surgical services have large disparities. For example, patients saw out-of-network behavioral health providers at much higher rates than physical health providers
- People with mental health problems are more likely to have no insurance or to be on public insurance. Those individuals, even if insured, face the barrier of inability to pay for treatment, due to high treatment costs and/or inadequate insurance coverage

Barrier to Behavioral Health: **Coverage** (cont.)

Disparity Impact:

- Latino, American Indian, and Alaska Native communities: Latino, American Indian, and Alaska Native people are all at least 2.5 times more likely to be uninsured than non-Hispanic white people
- Uninsured adults with mental illness: Only 20 states saw a reduction in adults with any mental illness who were uninsured. The largest reductions were seen in Louisiana (5%), South Dakota (3%), Kentucky (2%) and Kansas (2%). The largest increases were seen in Iowa (5%), Mississippi (4%), Arkansas (4%)
- Children: The rate of children with private insurance that does not cover mental or emotional problems decreased 0.3% from 2020 to 2021. However, there are still 901,000 youth without coverage for their behavioral health

Barrier to Behavioral Health: **Wait Times**

Definition: The opportunities, in general, for consumers to access the healthcare system (i.e., wait times).

Research-Based Evidence:

- Many communities across the United States have limited or no access to true "no wrong door" crisis services. Because of this, individuals must default to law enforcement to operate as community-based mental health crisis response teams. Law enforcement have few options to connect individuals experiencing a mental health crisis to care in real time
- Mental health and substance use-related ED visits increased more than 44% between 2006 and 2014, with suicidal ideation visits growing by nearly 415%
- 70% of emergency physicians surveyed reported psychiatry patients being boarded on their last shift
- Few states, including AZ, GA, and TN, have developed behavioral health crisis models of care that provide early intervention and divert individuals in crisis from hospitals, jails, and prisons. While research finds good fiscal and clinical outcomes, this state level approach has not proliferated across the nation

Disparity Impact:

- Rural and frontier communities: Rural and frontier communities face unique workforce and geographic challenges that make it more difficult to deliver high quality crisis services that meet the needs of the region. These communities are at risk of experiencing mental health and substance use crisis. When this occurs, these individuals need access to care that meets their needs in a timely manner like in urban communities

Barrier to Behavioral Health: **Cultural and Linguistic**

Definition: Inadequate cultural representation or understanding within clinicians and a lack of interpreter services in the healthcare system.

Research-Based Evidence:

- Adherence to the 15 standards for implementing culturally competent care, the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), is quite variable
- Cultural care for managing behavioral health crises in the Emergency Department is lacking
- Communication patterns across racial and ethnic patient-clinician dyads during mental health intake are connected to continuance in care
- % of all psychologists were non-Hispanic White
- 8463% of census respondents who reported limited English proficiency (LEP) were Latino. In general, people who speak English as a second language (Spanish, Portuguese, etc.) lack healthcare information in their native languages

Disparity Impact:

- Children: Limited English proficiency (LEP) in children affects their behavioral health care.
- Limited English proficiency communities: Linguistic barriers prevent Chicago-area locals from gaining adequate mental health services. For example, few providers in the suburbs of Chicago speak Arabic, making care for Arabic-speaking people very difficult
- Black communities: Many Black people have general mistrust for mental health professionals due to a lack of cultural competency

Barrier to Behavioral Health: **Fear of Repercussions**

Definition: People may forego care because of negative lawful consequences that come with certain illicit substances or mistreatment of those in behavioral health crisis.

Research-Based Evidence:

- Law enforcement's function as a stopgap for mental health care access has deadly consequences: approximately 25% of fatal police shootings involve signs of mental illness
- The cycle of fear among providers, patients, and families contributes to a negative culture and poor quality and experience of care

Disparity Impact:

- Hispanic/Latino communities: In Hispanic/Latino communities, fears and stress related to immigration status are pervasive. Many documented and undocumented Hispanic/Latino people will not seek treatment for themselves, family members or friends for fear of deportation
- People of color: 54% of people who died as a result of harm from police and whose race was identified were people of color—including Asian, Black, Hispanic, Native American, and Pacific Islander individuals
- Black communities: Black communities have historically faced stricter enforcement of drug policies as a result of local laws like the Rockefeller Laws in New York and federal laws like the Anti-Drug Abuse Act of 1986. This disparate enforcement has resulted in severe sentencing for low-level, nonviolent drug offenses, particularly related to cocaine, for a disproportionately high number of people of color compared to White people

Barrier to Behavioral Health: **Social Factors**

Definition: Social factors, like a lack of housing, food, and transportation, may bar individuals from accessing the system.

Research-Based Evidence:

- Social determinants of health (SDOH) influence mental health outcomes but SDOH data are not systematically integrated to inform patient care. Better collection and processing of SDOH would close barriers to mental health access and improve health equity
- 20% of all veterans treated for mental health issues through the Veterans Health Administration received community-based services aimed at addressing social determinants of health. Services included housing and vocational programs
- 58% of Medicaid patients surveyed said they could not make medical appointments without non-emergency medical transportation. Primary care appointments are vital in identifying and preventing medical conditions in the short and long-term

Disparity Impact:

- Individuals seeking mental health care: "Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk"
- Individuals with severe mental illnesses: Individuals who have severe mental illnesses are more likely to suffer from social factors like food and housing insecurity. Ethnic and racial minorities disproportionately suffer from chronic poverty issues, which are known to be connected to worse mental and behavioral health problems

Provider Delivery Barriers

Systemic challenges that limit the ability of *providers* to meet the behavioral health care needs of patients and communities:

- **Payment and reimbursement** that is not adequate to cover cost of services
- Insufficient **workforce development** to ensure providers are proficient to support the needs of patients with behavioral health conditions
- **Workforce shortages** in key disciplines that traditionally manage and treat behavioral health conditions

Barrier to Behavioral Health: **Payment & Reimbursement**

Definition: The reimbursement rates and payment methodologies utilized by public and private payers for behavioral health services limit the capacity of providers to fully meet patient and community needs.

Research-Based Evidence:

- The U.S. spent $170 billion on behavioral health in 2009. That is compared to $777 billion for hospital care, $503 billion for physician and clinical services, $255 for prescription drugs, and $102.5 billion for dental services. Inadequate funding for behavioral health still persists today
- One of the primary reasons for the U.S.'s behavioral health workforce shortage is the lack of payment. Not only are salaries comparably low for behavioral health workers when compared to other areas of the medical field, reimbursement is also consistently lower
- Retention of behavioral health professionals has been difficult due to low wages and poor benefits
- Behavioral health providers face significant structural and policy barriers to value-based payment (VBP) adoption despite the opportunity VBP provides to improve quality and access to behavioral health care
- In-network behavioral health providers were reimbursed at lower rates than their medical/surgical counterparts in 2017, representing a violation of parity laws

Barrier to Behavioral Health: **Payment & Reimbursement** (cont.)

Research-Based Evidence:

- Local Medicaid policies in Michigan vary on how behavioral health providers (specifically clinical psychologists and licensed clinical social workers) can bill for services
- 9% of surveyed health plans, reimbursed for consultation services between primary care and behavioral health providers
- Public reimbursement for many services delivered by psychologists have been declining since 2001

Disparity Impact:

- Behavioral health workers and rural communities: Low salaries for behavioral health workers compared to other health care professions in Colorado was a significant problem in the workforce shortage, especially in more rural parts of the state

Barrier to Behavioral Health: **Workforce Development/Training**

Definition: Lack of education among the broader healthcare workforce on identifying and addressing behavioral health conditions, as well as a lack of training of behavioral health professionals. A robust behavioral health workforce is essential to meeting the needs of patients with mental health and substance use conditions. Training of primary care providers in identifying and treating behavioral health conditions augments specialty care providers and increases access to care.

Research-Based Evidence:

- One key way states have been handling workforce shortages in behavioral health is through non-licensed staff. Most states now reimburse a broad range of titles like peers, non-licensed counselors, and other qualified staff for delivering certain services. However, training and education vary greatly from state-to-state for non-licensed staff

Barrier to Behavioral Health: **Workforce Development/Training** (cont.)

Research-Based Evidence:

- Within the behavioral health workforce, one of four focus areas in 2015 was Education and Training. Key findings in that section included the following:
  - Behavioral health students are siloed in education programs
  - There is a lack of behavioral health training for advanced practice registered nurses (APRNs) and physician assistants (PAs).
- Clinicians working in primary care, both physicians and non-physicians, are dealing with behavioral health more and lack adequate training

Disparity Impact:

- Racial and ethnic minority communities: Striking disparities exist for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services and are less likely to receive needed care than white patients. When they receive care, it is more likely to be poor in quality

Barrier to Behavioral Health: **Workforce Shortages/Pipeline**

Definition: Insufficient numbers and types of licensed behavioral health professionals available to provide needed services to people with mental health and/or substance use disorders. A robust behavioral health workforce is essential to meeting the needs of patients with mental health and substance use conditions.

Research-Based Evidence:

- 41% of respondents surveyed said that availability of in-network providers was one of two of the largest barriers to care
- Between 2017 and 2030, there will be a 20% drop in adult psychiatrists: from 33,650 to 27,020. If there are only 27,050 adult psychiatrists practicing in 2030, over 12,000 more adult psychiatrists would be needed to adequately treat Americans
- Only 28% of behavioral health care need is met in the 5,930 health professional shortage areas (HPSA) across the United States in quarter four of fiscal year 2021. To fill this void, 6,559 mental health professionals are needed

Disparity Impact:

- Children: 70% of counties in the United States did not have a child psychiatrist in 2007 or 2016. Low-income and less educated areas were also less likely to have child psychiatrists
- Non-metropolitan communities: Metropolitan areas had over three times as many psychiatrists per capita as those in non-metropolitan areas in 2015 (per U.S. Census regions). 27% of counties in metropolitan areas are without a provider while 65% of non-metropolitan counties are without a provider
- Asian, Black, and non-white Hispanic communities: Asian, Black, and non-white Hispanic psychologists combined to make up less than 15% of all psychologists in the U.S. in 2015

There are several key takeaways from reviewing the research on barriers that should be considered as policies are developed:

- ★ Barriers stem from policy, care delivery, or societal challenges that limit accessibility for people.
- ★ Barriers to care do not impact all populations the same way. Barriers can be mitigated or exacerbated based on demographics, including race, ethnicity, age, gender, geographical region, and socioeconomic factors. Underserved populations, like people of color and those living in rural areas, are disproportionately impacted by barriers to behavioral health care.
- ★ Barriers may be heightened by clinical condition or acuity. The efficacy of telehealth works may depend on the skills of the therapist, the nature of the therapy, and the client's cognitive abilities and needs. Telehealth may not replace the social interactions that are core to a recovery-oriented group, for example. Clients with severely impaired functioning may also find telehealth challenging.
- ★ Continued research should be conducted to understand how barriers intersect with socio-demographic and clinical factors to identify equitable and people centered solutions to accessing behavioral health care.
- ★ Proposed solutions must be developed and implemented based on research findings and inclusive of input from with those with lived experiences, patients, families, and providers.

For more information, please contact:

help@usofcare.org