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Increasing equity in access to mental health care: a critical first step in improving service quality

As Kilbourne et al¹ describe, measuring quality of mental health care serves as an important step towards reducing service inequities. However, quality measurement that predominantly focuses on treatment outcomes overlooks individuals with mental health needs who cannot access value-based treatments. Untreated mental health and substance use disorders are associated with premature mortality, productivity loss, high rates of disability, and increased risk for chronic disease. Thus, ensuring equitable access within a value-based framework is needed to not only close existing treatment gaps but also to improve patient outcomes.

The degree of inequity in access to mental health care varies among countries with different models of health care system and welfare regimes. Findings from a study of seventeen low-, middle- and high-income countries revealed low mental health care utilization despite documented high need: in each country, at least two-thirds of individuals with common mental disorders went untreated². Twelve-month service utilization rates also tended to be lower in less developed countries and to align with the percentage of gross domestic product spent on health care³. Furthermore, members of socially disadvantaged groups such as ethnic/racial minorities and low-income patients have lower mental health service utilization compared with members of advantaged groups⁴.

Inequities in access to mental health care can arise due to myriad reasons, including: eligibility criteria to enter programs (e.g., receiving a specific required diagnosis); lack of linguistic capacity; policies that discriminate based on legal status (e.g., refugees, immigrants, racial/ethnic minorities); lack of information regarding where and how to obtain care; and logistical, psychological and economic barriers (e.g., transportation, childcare, beliefs about self-sufficiency, stigma-related concerns, concerns about pri-

vacy, long waiting times for services, high costs, or inflexible work schedules). To adequately document mental health care inequities, measures and procedures to evaluate access must be consistently and globally implemented across mental health care systems. But you cannot evaluate what you have not measured, and unmet need is typically absent from conventional administrative or service data.

Methods of measuring access might focus on one's potential ability to access care, including the package of benefits included under mental health coverage and the availability of appropriate and effective service providers within reasonable geographic proximity. Additionally, access measures should incorporate obstacles that arise once someone has decided to enter care, such as insufficient choice of providers, low doses of services, and ineffective or low-quality services. In a value-based framework, both horizontal equity (understood as the provision of equal care for equal needs) and vertical equity (understood as different treatments for people with different needs or preferences) must be considered when striving for equitable access.

Conducting national surveys of household and institutionalized individuals every five to ten years might offer a benchmark of those who need care and where they are located. Results of such investigations can also inform testable hypotheses about why some individuals do not receive services, including explanations related to specific preferences for care. Additionally, quick assessments obtained through computerized adaptive testing might simplify diagnostic evaluation and assure linguistic diversity, as well as afford more attention to differential item functioning (i.e., the extent to which an item measures different abilities for members of different groups), so that providers can adequately operate across cultures, diverse populations, and languages⁵. Measuring both barriers and facilitators to mental health and substance use treat-

ment access through geographic mapping can also provide a more comprehensive picture of specific areas in need of immediate intervention. Finally, overlapping measures of need with administrative service use data can facilitate allocation of resources, adjustments of risk for inclusion of underserved populations, and payment incentives for providers to reach those with unmet behavioral health needs.

But, before these methods can be widely adopted, a shift in the purpose of medical records (i.e., from being used mostly for billing to being used predominantly to monitor access, quality, and patient's service preferences) must come into vogue. Stratification by need level (e.g., those with comorbid conditions), age, race/ethnicity, income, sexual orientation, gender, urbanicity, or linguistic subgroups can assist in isolating where there are inequities and who or what is responsible for them. However, it will likely be more difficult to make the health care system accountable for collecting these data, given the inadequate budgets and resources granted by ministries of health for mental health care⁶.

Despite having several potential methods to measure access to mental health and substance use care, systems may not utilize these methods in a meaningful way if they are not incentivized to do so. Although reporting requirements tied to provider accreditation or funding vary across oversight agencies, states and countries, they typically focus on service outcomes of those *in care* rather than outcomes of those *eligible for services*. Recommended performance metrics that include access to care have been proposed by several relevant organizations but, without some form of mandated accountability, health care administrators do not reliably collect or report this information⁷.

More research should focus on strategies to make service administrators and policy makers responsive to reducing access inequities and incentivized to develop

leadership, implementation plans, and resources to ensure prompt action. As the field stands now, recommended paths seem to converge on care that maximizes value for patients rather than volume and profitability of services⁸. Transitioning to value-based care delivery should force health care systems to focus more on potential and existing patients, as well as those patients' preferences and needs.

Many creative solutions have been offered to increase access, including integrating behavioral health services into primary or community-based care, augmenting the workforce through task-shifting (e.g., utilizing community health workers or peer navigators to provide some services), imparting training and supervision to novel providers via the Internet, or delivering services to people where they live (e.g., via minute clinics, medical vans, or telemental health services) rather than expecting people to travel long distances to access services^{9,10}.

But it is surprising that, given all we know about how to expand access, re-engineering service delivery seems sluggish. Why is access not a priority given existing rates of untreated mental health and substance use disorders? Have we not made a compelling case to policy makers,

the general population, or health care system leaders? Do we need more evidence than the opioid epidemic, the massive incarceration of people with mental health conditions, or the suicide pandemic?

Now, more than ever, maximizing patient outcomes will require reaching out to patients earlier in their illness trajectory, helping them recognize mental health needs, and making them co-leaders in their care. It might necessitate psychoeducation dissemination campaigns, home visits, and continuous communication to understand what patients prefer as high-value health care delivery. It will also entail measuring mental health outcomes that matter to the patient rather than mental health outcomes related to symptoms, even when those patients do not always come to care.

We have an ethical obligation to make our communities healthier, with a universal approach to treatment rather than treatment for the very few. Like Martin Luther King Jr. said, "of all forms of inequity, injustice in health care is the most shocking and inhumane".

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Mental health quality improvement goes global

The field of quality assessment in health care traces its origins back more than 50 years to A. Donabedian's seminal article outlining a framework for understanding quality of care from a health systems perspective¹.

Quality improvement in mental health is a younger enterprise. A 2006 report from the US Institute of Medicine outlined the challenges in assessing and improving quality of care for mental disorders, including lack of standardized approaches for diagnosing mental health and substance use disorders; limited evidence base supporting current quality measures, and fragmentation and lack of information technology infrastructure to measure quality. Nonetheless, the report argued that quality improvement princi-

ples could, and should, be applied to efforts to improve mental health care².

Since the publication of that report over a decade ago, innovations in health technology, the growth of large integrated health systems, and movement of mental health into the mainstream of health care have helped spur a rapid growth of mental health quality improvement in the US³.

Kilbourne et al's important paper⁴ provides an update on the state of mental health care quality improvement worldwide. The authors describe initiatives to measure and improve care within the US and other developed countries, and make recommendations to better incorporate them into routine practice. The paper provides a valuable framework for under-

standing quality improvement from an international perspective.

There are tensions inherent in mental health care quality improvement that become particularly evident in efforts to consider this process from a global perspective. Historically, performance measurement systems in the US and other developed countries have been built on existing administrative datasets⁵. The elements of these datasets vary across countries and health systems – for instance, fee-for-service systems typically aggregate billable claims, whereas countries whose systems focus on inpatient care primarily collect data from these settings.

Differences in structure and financing of mental health systems may shape the availability of data and constrain the col-