

Access to Outpatient Mental Health Care in Walla Walla County

by

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*Certificate of Approval*

This is to certify that the accompanying thesis by Sara J. Federman has been accepted in partial fulfillment of the requirements for graduation with Honors in Psychology.

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## Table of Contents

Acknowledgements.....	iv
Abstract.....	v
Introduction.....	1
Theory and Literature Review .....	2
From Institutions to Emergency Rooms .....	2
Access to Mental Health Treatment: Five Barriers.....	3
Walla Walla County: A Case Study.....	9
State and Federal Context .....	9
Barriers to Care in Walla Walla County .....	10
Current Study .....	14
Methodology .....	16
Participants.....	16
Measures .....	16
Procedure .....	17
Data Analysis .....	18
Results.....	20
1. Knowledge Barriers .....	20
1a. Problems with the Provider Search .....	21
1b. Mental Health Literacy Matters .....	22
2. Attitude Barriers.....	23
2a. Delaying Care.....	24
2b. Stigma in a Small Community .....	25
3. Insurance & Price Barriers.....	26
3a. Restricted Provider Options .....	26
3b. Private Insurance: Inconsistent Coverage, Inconsistent Costs.....	27
4. Delivery Barriers.....	29
4a. Low Availability, High Demand.....	29
4b. Finding Fit.....	31
4c. Problems with Prescribers.....	33
Discussion .....	36
Limitations & Future Directions.....	38
Recommendations.....	40
Recommendations for Mental Health Care Providers .....	40
Recommendations for Doctors (PCPs and other generalists).....	41
Recommendations for County Leaders (county officials, heads of local organizations) .....	43
Appendix A: Interview Outline .....	44
Appendix B: Recruitment Materials .....	46
Appendix C: Theme & Sub-theme Frequencies .....	48
Bibliography .....	49

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## **Abstract**

Access to mental health care has repeatedly been identified as an area of concern in Walla Walla County. However, few details are known about barriers that limit local access to care and whether these barriers differ across sociodemographic groups. This exploratory study set out to determine specific barriers to care by comparing county residents' experiences of accessing outpatient mental health services. Additionally, this research examined potential disparities in access to care by comparing experiences of county residents with private and public health insurance. Twenty county residents, 9 with private insurance and 11 with public insurance, participated in semi-structured interviews to discuss their access to mental health services within the county. Framework analysis was used to identify several themes and sub-themes to describe barriers faced by individuals in need of local mental health services. Analysis relied on a general framework of barriers to care proposed by the nonprofit Health Care for All. This framework was used to categorize participants' experiences into four themes: knowledge, attitude, price & insurance, and delivery-related barriers to care. Results yielded nine specific sub-themes that capture precise barriers to care across all participants, ranging from 'problems with prescribers' to 'stigma in a small community.' Few substantial differences in barriers to care were found between insurance groups, although privately insured individuals tended to have higher out-of-pocket costs and broader access to private mental health practitioners. Recommendations for how mental health providers, doctors, and county leaders can mitigate barriers are discussed.

## **Introduction**

In the United States, half of the 60 million individuals living with a mental health condition receive no treatment whatsoever (National Alliance on Mental Illness, 2017). Mental illness, especially when untreated, is associated with significant adverse physical health consequences. Life expectancy among those with mental disorders in the U.S is lower than the general population by an average of 8.2 years, and approximately 8 million deaths worldwide each year are attributable to mental illness (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Walker, McGee, & Druss, 2015). Mental health and substance abuse disorders are also among the leading causes of disability in the U.S (Murray et al., 2013). Despite the clear interaction between mental and physical health, mainstream health care delivery systems continue to treat the two as separate entities.

Compared to other forms of care, quality mental health care remains persistently more difficult to access for the vast majority of Americans (National Alliance on Mental Illness, 2017; Melek, Davenport, & Gray, 2019). Generally, a patient who enters a doctor's office with a broken arm will find themselves on a fairly straightforward path to recovery. A patient in the same office because of severe depression, however, will face a disproportionate number of obstacles in the course of their treatment. Mental health stigma, fragmented mental health care delivery systems, inadequate insurance coverage for mental health, lack of culturally competent providers, and high costs are among the many barriers preventing individuals from getting the care they need (Health Care for All, 2017). These barriers, which have contributed to a national mental health crisis, arose historically from a series of well-intentioned policy decisions that ultimately weakened the public mental health system.

# **Theory and Literature Review**

## **From Institutions to Emergency Rooms**

In 1955, state psychiatric hospitals across the United States provided over 550 thousand beds for inpatient care (Pinals & Fuller, 2017). As of 2018, that number had dropped to approximately 36 thousand (National Mental Health Services Survey, 2018). The large disparity between these two figures represents the fundamental reconceptualization of the mental health system that emerged during the deinstitutionalization movement in the second half of the 20th century. From their establishment in the 19th century up until deinstitutionalization, state psychiatric hospitals functioned as the entirety of the mental health care system in the United States. By the mid 20th century, overcrowding and underfunding of state psychiatric hospitals resulted in deteriorating quality of care; a series of exposés detailing the often-dire conditions inside such institutions generated public outrage and contributed to the growing push for deinstitutionalization (Hunter, 1999). At the same time, the development of psychiatric medications such as Thorazine allowed many mentally ill individuals to achieve stabilization, which greatly eased their ability to reintegrate into their communities. The deinstitutionalization movement culminated in the 1963 Community Mental Health Act (CMHA), which provided federal funding for states to create community mental health centers (CMHCs) and called for community-based treatment to replace institutionalization as the standard of care.

Over the next several decades, however, the opportunity for states to provide community-based care suffered under a combination of federal budget constraints and

amendments to the CMHA which led to sharp decreases in available federal funds (Sharfstein, 2000). Newly created CMHCs struggled to support the influx of patients arriving from state psychiatric hospitals, many of whom were unable to pay for services (Mulligan, 2004). At the same time, the exclusion of Institutions for Mental Disease (IMDs) from Medicaid reimbursement further incentivized states to downsize or close state psychiatric hospitals, resulting in the site of acute psychiatric care to shift heavily from state hospitals to psychiatric wings of general hospitals and private psychiatric specialty hospitals (Fisher, Geller, & Pandiani, 2009). Emergency departments (EDs) became the standard site of acute psychiatric care, and continue to function as such to this day; in 2014, there were approximately 2.5 million ED visits in the U.S primarily related to mood or anxiety disorders and an additional 760,000 related to psychotic disorders (Agency for Healthcare Research and Quality, 2017). The persistently high need for emergency psychiatric care suggests that many individuals with mental health conditions do not have adequate access to needed mental health services that may prevent such crises (Wingerson, Russo, Ries, Dagadakis, & Roy-Byrne, 2001). Consequently, attempts to reduce the need for psychiatric care in emergency departments will require policymakers and health care providers to look upstream at the barriers that limit groups and individuals from accessing appropriate mental health treatment earlier in the course of their mental illness.

### **Access to Mental Health Treatment: Five Barriers**

Determining the barriers that prevent or limit access to mental health care first requires a clear definition of the word *access*. In health care settings, access to care encompasses both the availability of needed services and the extent to which individuals



actually enter the health care system to receive needed services (Aday & Anderson, 1974). Barriers to access, then, stem from either the unavailability of services or from the inability or unwillingness of individuals to obtain available services. The latter explanation requires further specification, however, given the wide variety of factors that can affect a person's likelihood to access available services.

Health Care for All, a nonprofit focused on health care equity, identified five categories of barriers to mental health care access based on results from their yearlong study of Massachusetts residents living with mental illness, health care providers, and policy experts (Health Care for All, 2017). The data, which relayed individuals' lived experiences of the mental health care system through surveys and focus groups, revealed that the presence of knowledge barriers, attitude barriers, insurance barriers, price barriers, and delivery barriers limit individuals with mental illness from accessing appropriate mental health care. As outlined below, they provide a framework for the analysis of access to mental health care in the present study.

*Knowledge barriers* pose problems for individuals with low mental health literacy. Mental health literacy describes the extent of an individual's knowledge of mental illnesses, including knowledge of their symptoms, risk factors, and appropriate treatments (Mendenhall & Frauenholtz, 2013). Those who lack knowledge of the symptoms of mental illness may misinterpret or fail to detect the onset of symptoms in themselves or their loved ones, which can then prevent access to treatment, especially early in the course of mental illness. Longer duration of untreated mental illness is associated with poorer outcomes after eventual treatment across a variety of disorders (Dell'Osso, Glick, Baldwin, & Altamura, 2013). Even for those who recognize their

mental illness, knowledge barriers tend to delay the treatment process. After realizing the need for treatment, an individual may still not know what kind of treatment fits their needs, where they can access it, or how to make sense of their health insurance plan, all of which are crucial for obtaining care (Health Care for All, 2017).

*Attitude barriers* stem from the stigma around mental illness that renders individuals less likely to acknowledge their own illness or seek care. Stigma, which results from inaccurate stereotypes of persons with mental illness as dangerous or incompetent, brings prejudice and social exclusion upon individuals labeled as mentally ill. For those with internalized stigma, a diagnosis of mental illness can be shameful and may negatively impact self-worth. Others may simply fear the ostracism and discrimination they may face due to stigmatizing attitudes held by their family, friends, or others in their community. In either case, stigma can discourage acknowledgement of symptoms, disclosure of mental illness, and treatment seeking (Corrigan, 2004). The effects of stigma around mental illness tend to be more salient within certain groups—for example, stigma has a disproportionately negative impact on help-seeking behavior for mental illness in ethnic minority group members, young people, men, people in the military, and people in health occupations (Clement, Schauman, Graham, Maggioni, & Evans-Lacko, 2015). Attitude barriers may also include beliefs about being able to manage a mental health problem on one's own, or skepticism over the effectiveness of treatment.

*Insurance barriers* involve the challenges health care consumers face when seeking out care within a confusing and complex health insurance system. In 2017, 91.2% of people in the U.S had health insurance, with over 67% of people covered by

private insurance and over 37% covered by some variety of public insurance (Berchick, Hood, & Barnett, 2018). Despite high rates of coverage, actually finding and obtaining appropriate mental health services covered by insurance remains a difficult task for many. Though insurance companies are required to keep provider directories for consumers, those using directories often find that many or all listed providers are either not taking new patients, have moved away, no longer accept insurance, or are deceased (Health Care for All, 2017). Insurance companies continue to violate the 2008 Mental Health Parity and Addiction Equity Act, which requires insurers to provide the same extent of coverage for behavioral and physical health services. Insurance provider networks for mental health services remain inadequate compared to networks for physical health services, resulting in dramatically higher utilization of out-of-network services for mental health than for other health services (Melek et al., 2019). For consumers able to find covered mental health providers, actually receiving reimbursement for services from their insurer can require persistent communication and self-advocacy. Private insurance plans, which cover the majority of people in the U.S, generally offer less generous mental health care benefits than Medicaid plans (Rowan, McAlpine, & Blewett, 2014). When those in need of services are unable to find an in-network provider or are denied coverage, they are forced to either pay out-of-pocket or forgo treatment.

*Price barriers*, which go hand in hand with insurance barriers, represent the prohibitive out-of-pocket costs that are associated with mental health services. For those with insurance, deductibles, frequent co-pays for appointments, and the cost of psychiatric medications can be a severe financial burden. Prescription costs account for two thirds of mental health out-of-pocket spending, yet the high cost of psychiatric

medication has not been addressed by parity legislation (Zuvekas & Meyerhoefer, 2009). Individuals who are older, privately insured, or more educated pay the largest share of out-of-pocket expenditures, which likely reflects the ability of these groups to afford services that require high out-of-pocket costs (Ringel & Sturm, 2001). Many people make treatment decisions on the basis of cost and will simply go without treatment if costs are too high. Compared to those in other western nations, low-income residents in the U.S are significantly more likely to face financial barriers to mental health treatment (Sareen et al., 2007). Furthermore, severe mental illness frequently renders people unable to work for prolonged periods of time, which results in decreased income and sometimes loss of employment-based insurance. Price barriers tend to disproportionately affect racial and ethnic minorities, who experience higher rates of poverty and lower rates of insurance coverage than non-Latinx whites (Alegría et al., 2008). The strong association between poverty and severe mental illness in the U.S speaks to the financial inaccessibility of proper mental health services for many nationwide (Vick, Jones, & Mitra, 2012).

*Delivery barriers* comprise the challenges involved with finding effective, culturally appropriate, and logistically suitable mental health treatment for a given individual. Because mental health services are inherently personal, the partnership between providers and consumers is crucial to treatment success. Employee turnover in the mental health workforce is high, and providers are predominantly white (U.S Department of Health & Human Services, 2001; Health Care for All, 2017). Lack of multicultural representation and awareness among providers furthers disparities in the quality of care received by members of racial and ethnic minority groups (Valdez, Dvorscek, Budge, & Esmond, 2011). Unfortunately, a single bad experience in a mental

health care setting may deter an individual from seeking out care in the future. Even when appropriate and quality services are available, geographical distance from providers, lack of transportation, language barriers, or restricted hours of operation can make outpatient services especially difficult to access.

These five categories cover a broad array of obstacles that those with mental illness may encounter in their journey toward recovery. Taken together, they help explain why the time elapsed between mental illness onset and first treatment can average several years, even in severe cases where symptoms are highly visible (Wang, Berglund, Olfson, & Kessler, 2004). Critically, delivering information about specific barriers to lawmakers provides them with focused targets for potential policy changes. The extent and intricacies of each type of barrier, however, vary between individuals, demographic groups, and entire communities. Focusing on the community level, where resources, policies, and demographics may vary widely from state or federal levels, allows for a more precise and actionable examination of access to mental health care. The present study utilizes the framework proposed by Health Care for All to examine barriers to accessing mental health care at the community level in Walla Walla County of Washington State.

## **Walla Walla County: A Case Study**

### **State and Federal Context**

Understanding access to mental health care at a community level requires consideration of the local, statewide, and federal contexts that affect access to care. At a federal policy level, the combination of persistent underfunding of state mental health agencies, low reimbursement rates for mental health providers, ongoing mental health workforce shortages, and poor enforcement of mental health parity laws have limited access to timely, affordable mental health services nationwide (American Hospital Association, 2019). Federal funding mechanisms have entrusted more responsibility to states over providing mental health care than other types of health care, meaning that the quality and availability of mental health services can vary vastly from state to state (Hogan, 1999).

Washington state is one of the lowest-ranking states in the country for adult mental health. The state has the third highest statewide prevalence of any mental illness (AMI) among adults, yet also has one of the lowest per capita availability of psychiatric beds (Washington State Institute for Public Policy, 2015). Across the state, nearly 1.3 million adults report having any form of mental illness, and over 700,000 of those adults receive no treatment. Of adults who seek out services, 327,000 adults still report having unmet treatment needs (Mental Health America, 2019). Between 2012 and 2014, mental health conditions were the 5th most common cause of hospitalization in the state—ranking higher than injuries—and were associated with the longest average length of stay (Washington State Department of Health, 2014). In response to the statewide mental

health crisis, recent legislative state lawmakers and current governor Inslee have passed several pieces of legislation to improve the statewide mental health. The 2019 state legislature invested \$455,681,000 in behavioral health programs, an improvement from years' past (NAMI Washington, 2019). Statewide priorities include expanding mental health treatment options at the community level and integrating physical and behavioral health care (Washington Office of the Governor, 2018).

### **Barriers to Care in Walla Walla County**

Walla Walla County, a rural county in southeastern Washington, is home to 60,567 residents across 4 cities and 6 census-designated places (County Health Rankings, 2019). The city of Walla Walla, with 32,986 residents, is the largest in the county, and is where most of the county's mental health resources are located (United States Census Bureau, 2018). Across its municipalities, however, Walla Walla County has a disproportionately small mental health workforce. The county population to mental health provider ratio is 410:1, compared to the statewide ratio of 310:1, and the county has 0 certified psychiatrists (County Health Rankings, 2019). For psychiatric medication management, residents must seek care from general doctors or one of the county's few psychiatric nurse practitioners (NPs). For outpatient mental health counseling, options for service providers are more varied, and include private practitioners, local community mental health centers, the Veteran's Affairs Medical Center (VA), and other local nonprofit organizations. Residents experiencing a mental health crisis, however, have fewer options for treatment. Until recently, there were no psychiatric inpatient treatment facilities within the county. In response to the county's shortage of intensive treatment centers, Comprehensive Healthcare, the private nonprofit organization that operates a

local outpatient community mental health center, opened Waypoint in 2018 in the city of College Place. Waypoint is a 16-bed residential behavioral health facility, and its staff works closely with Providence St. Mary's Hospital—the county's only ED—to provide transitional care for discharged patients with high behavioral health needs.<sup>1</sup>

Although it collaborates with Waypoint and its crisis team, Providence St. Mary's Hospital does not offer inpatient psychiatric services, and is not an optimal place for people with behavioral health needs to receive treatment. Nevertheless, 32% of patients seen at the hospital have a behavioral health condition. For mental health-related emergency department visits at Providence St. Mary's between 2018 and 2019, 42.1% of visits resulting from serious persistent mental illness and 34.0% of visits from other mental illness were classified as avoidable. Individuals with mental illness who persistently cannot access outpatient care may have symptoms worsen in the absence of treatment, which can require ED use if symptoms become especially severe. A large proportion of psychiatric ED visits are thus considered avoidable, as they likely reflect inadequate access to outpatient care (Hsia & Niedzwiecki, 2017). Avoidable ED use harms patients, who may experience significant stress and trauma during hospitalization; relatedly, the high financial burden of these avoidable visits can harm hospitals themselves (Abid, Meltzer, Lazar, & Pines, 2014). At Providence St. Mary's Hospital, slightly less than one third of patients seen at the ED have a mental health condition, but the majority of ED costs come from mental health and substance use disorder-related

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<sup>1</sup> The current research focuses specifically on mental health, which is one aspect of behavioral health. Behavioral health also includes conditions and services related to substance use and addiction.



visits. Such high costs largely stem from the relatively high service needs and long average lengths of stay for behavioral health patients.<sup>2</sup>

Further evidence of unmet mental health needs in the county can be found outside of the ED. The suicide rate in Walla Walla County, at 15.1 per 100,000 deaths, exceeds the statewide average of 13.8 per 100,000 deaths. Overall, 11% of county residents report having poor mental health, and at the SOS Health Services clinic of Walla Walla, depression is the third leading diagnosis (Walla Walla Department of Community Health, 2014). Based on the prevalence of mental health needs in the community, Walla Walla County officials have repeatedly cited access to mental health care as a major community health priority. Improving access to care can involve increasing the number of providers to alleviate shortages. However, recruiting and retaining mental health professionals can be a major challenge, especially in rural counties such as Walla Walla (Moore, Sutton, & Maybery, 2010).

Though expanding the mental health workforce will remain to be an important piece of the long-term solution, another approach to improve access to care involves reducing barriers that prevent individuals from using services that are already locally available. However, as detailed previously, barriers may not affect all populations to the same extent. For example, sociodemographic factors are important to consider when assessing barriers to care. Across the U.S, systemic disadvantages for racial and ethnic minorities, LGBTQ individuals, people living in rural communities, and various other

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<sup>2</sup> Data on ED use and costs for Providence St. Mary's Hospital come from unpublished reports that the hospital agreed to share with the Walla Walla Department of Community Health for planning and policy purposes.

historically marginalized populations mean that access to care and treatment outcomes are often worse for these groups (National Conference of State Legislatures, 2018). A 2008 national survey by Alegria et al. found that members of racial and ethnic minority groups were less likely than non-Latinx whites to have access to quality mental health care. The authors found that 63.7% of Latinos, 68.7% of Asians, and 58.8% of African Americans diagnosed with a depressive disorder did not access any mental health treatment in the last year, compared to 40.2% of non-Latinx whites. These findings likely represent broad, historically rooted inequities that affect the ability and likelihood of minority group members to access mental health care at all levels. In Walla Walla County, nearly 30% of residents come from a minority racial or ethnic group: 21.5% are Latinx, 2.8% are multiracial, 2.3% are African-American, 1.8% are Asian, 1.4% are American Indian or Alaska Native, and 0.4% are Hawaiian Native or Pacific Islander (U.S Census Bureau, 2018).

Barriers to care would also be expected to vary depending on any given individual's health insurance coverage and income level (Health Care for All, 2017). In Walla Walla County, approximately 90% of county residents have health insurance, with the majority covered by private insurance and 27% covered by Medicaid (Walla Walla Department of Community Health, 2018). The proportion of the population covered by Medicaid highlights the relatively high number of low-income individuals living within the county. Medicaid tends to provide more reliable coverage for mental health services than private insurance; still, other low-income individuals whose income level exceeds the cutoff to qualify for Medicaid may be underinsured and face high out-of-pocket costs for health services (Rowan et al., 2014). For the majority of the county's population who

rely on private insurance, the amount of out-of-pocket costs for care may vary greatly depending on the quality of insurance plans offered by their employer.

## **Current Study**

Quantitative data related to insurance status, demographics, and local ED use provide some context around unmet mental health needs and potential disparities in access to care in Walla Walla County. To date, however, no research has been conducted on the extent of specific factors that limit access to outpatient mental health care in Walla Walla County. General figures, although helpful, do not point policymakers and health care providers towards concrete actions they can take to improve local access to mental health care. The present exploratory study, conducted in collaboration with the Walla Walla Department of Community Health, aims to fill this gap by providing county officials with precise information about local barriers to care based on county residents' lived experiences.

Building upon the framework proposed by Health Care for All, this research investigates the nature and extent of knowledge, attitude, price, insurance, and delivery barriers to care through semi-structured interviews with county residents who currently or previously have used local mental health services (Health Care for All, 2017). The primary intention of this research is to determine barriers that affect the community at large. Additionally, this research seeks to identify potential disparities in access to care among sociodemographic groups by comparing the various barriers faced by residents with private and public health insurance. Comparing the experiences of barriers faced by individuals at the local level shines light on ways in which local mental health care delivery systems perpetuate inequitable access to care. Ultimately, the findings from this

research can inform countywide priorities, policies, and funding decisions oriented towards improving access to mental health care.

## **Methodology**

### **Participants**

Twenty residents of Walla Walla County over the age of 18 participated in interviews during January and February of 2020. Sixteen participants spoke only about their own use of mental health care services in Walla Walla County, two spoke solely about service use by a family member whom they care for, and two spoke about both their own experience and those of family members they care for. All participants had health insurance at the time of interviews. In total, 45% of participants had private health insurance, and another 55% had public health insurance. Some individuals with public insurance were covered by multiple entities. Of those with public insurance, 72.7% had Medicaid, 27.2% had Tricare or VA benefits, 18.1% had Medicare, and 5% had subsidized health insurance through the Affordable Care Act marketplace. All of the privately insured participants went to private practitioners for outpatient mental health care. The majority of publicly insured participants went to Comprehensive Healthcare, although a few went to private practitioners or to the local VA Medical Center. Participant age ranged from 22 to 79 ( $M = 46.4$ ). Overall, 18 participants were non-Latinx white, 1 was Latinx, and 1 was biracial. Fifteen participants identified as female, 4 identified as male, and 1 identified as gender queer.

### **Measures**

Interviews were semi-structured, meaning the interviewer used the same pre-written list of questions for all interviews, but the flow and order of questions varied

based on participants' responses. All interviews began with a question about what mental health services the individual had used within the county. Most questions centered on the individual's ease or difficulty in accessing needed mental health care services. In keeping with the research question, questions were largely targeted towards potential knowledge, attitude, price, insurance, and delivery barriers. A few open-ended questions were included to ensure that participants had an opportunity to mention aspects of their experience that fell outside of these categories. At the end of each interview, the participant was asked about their age, gender, and racial identity. A complete outline of the interview questions can be found in Appendix A.

## **Procedure**

Paper flyers posted in public spaces throughout the county were used to recruit participants, as were electronic ads on Craigslist, Facebook, and community email listserves of Whitman College. Recruitment materials were posted in English and Spanish. Copies of recruitment materials can be found in Appendix B. Those who responded to advertisements were asked the following screener questions: "Have you or someone you care for received any form of mental health service in Walla Walla County (excluding services from a college or university)? Do you reside permanently in Walla Walla County? Are you over 18 years old? What type of health insurance do you use: private insurance, Medicaid, Medicare, or no insurance?" Inclusion criteria were satisfied if a prospective participant answered "yes" to the first three questions. Those who only used mental health services provided by their college or university were excluded because these services are unavailable for the vast majority of Walla Walla County residents. Funding provided by Whitman College for participant reimbursement allowed for up to

20 interviews. Responses about health insurance were used to track how many participants of each insurance status had been recruited to ensure a balanced sample. After the first wave of recruitment yielded a disproportionately high number of publicly insured participants, advertising efforts shifted solely towards those with private insurance. Successfully recruited community members were interviewed at a public location of their choosing. Before beginning the interview, participants were given an informed consent to read and sign. Afterwards, participants underwent a 30-minute semi-structured interview. Interviews were conducted in English. Spanish translation services were offered, but no recruited participants requested a translator. Interviews were not recorded, but the interviewer transcribed participant responses to questions via digital note taking. Transcripts from interviews were de-identified and stored on a password-protected file on a password-protected computer. After completing the interview, participants were debriefed by the interviewer and were provided with \$30 as compensation.

## **Data Analysis**

The task of identifying and comparing barriers to mental health care, which is primarily diagnostic in nature, lent itself well to framework analysis (Ritchie & Spencer, 1994). Framework analysis can be broken down into five stages. The first stage, *familiarization*, requires the researcher to immerse themselves in the data and take notes on generally observed patterns and key ideas. The second stage, *identifying a thematic framework*, builds off of these observations to develop themes or categories that can broadly represent commonalities across the data set. The third stage, *indexing*, involves identifying and labelling portions of data that correspond with each theme. The fourth

stage, *charting*, directs the researcher to physically group together the pieces of data indexed for each theme. Then, in the fifth stage, *mapping and interpretation*, the researcher looks for relationships and hierarchies within or across themes (Srivastava & Thomson, 2009).

Familiarization began after data collection ceased, at which time I individually reviewed all interview transcripts without any attempts to categorize or sort data. The five-barrier framework proposed by Health Care for All provided a tentative *a priori* thematic framework for the second stage of analysis (Health Care for All, 2017). I then indexed each transcript for lines of text that related to the four themes: knowledge barriers, attitude barriers, insurance & price barriers, and delivery barriers. I reviewed lines of text from each transcript that fit any given theme for redundancies and consolidated them when necessary. In a new document, I compiled 'charted' indexed, non-redundant lines of text together and separated theme by theme. Interpretation and mapping consisted of identifying sub-themes by grouping data within each theme that represented a common experience or belief. Data analysis took place in two rounds: once using the above process to compare data across all transcripts, and once using the same process to contrast data from transcripts of privately insured participants with that of publicly insured participants.



## **Results**

Though a couple of participants reported largely positive experiences regarding their access to local mental health care, the majority faced one or more major challenges. Because the barriers participants identified fit the framework proposed by Health Care for All, the proposed thematic scheme was maintained, though insurance and price barriers were combined into a single category to reflect their highly interrelated nature. Within the resulting four general themes—knowledge barriers, attitude barriers, insurance & price barriers, and delivery barriers—nine specific sub-themes were identified and are detailed below with supporting quotes from interviews. Because few major differences across the two insurance groups emerged, the majority of the results focus on results from the round of coding that compared barriers across all participants. Frequencies for themes and sub-themes are presented in Appendix C.

### **1. Knowledge Barriers**

Participants frequently described how their own knowledge (or lack thereof) about mental health and the mental health care system influenced their ability to obtain proper treatment, although the ways in which knowledge barriers impacted access to care varied. Some found the process of looking for a provider so effort-intensive that they postponed or gave up on the search entirely. For others, low mental health literacy led to unrecognized symptoms which delayed their decision to seek out care. Overall, participants' experiences reflected the unique knowledge burden placed on consumers of mental health care, who are often expected to know their own treatment needs and navigate through siloed health care delivery systems without much formal assistance.

## 1a. Problems with the Provider Search

A majority of participants reported difficulties related to their search for a local mental health provider. In particular, many reported feeling overwhelmed by the amount of knowledge needed to effectively navigate through the search process to find appropriate care. Participants described specific knowledge gaps that hindered their search, including: not knowing where or how to access current information about local provider options; not knowing the protocol around initiating service use; not knowing what services health insurance would cover; and confusion over different treatment types and provider certifications. For multiple participants, the search process itself became a source of dread and anxiety:

*...It's hard to tell from what's online, I had no idea what the stuff online meant, trying to figure out who did what and covered what was beyond what I could figure out... It's kind of like a wilderness to explore on your own, there's no one checking in on how it's going...it feels very isolating to try to access the right services with the right people. That's another reason it took me so long to look into it, it seemed overwhelming, especially with anxiety, I don't know what I need to share, how to make the appointment, there's no "this is how counseling goes" or if there's a limit. (Participant 18)*

*...I don't wanna wait until I'm in a crisis but the idea of doing all the research to find someone new and cross my fingers that it's a fit is exhausting. (Participant 20)*

Without formal channels for finding proper care, many participants relied on knowledge from others to find providers. When asked, “How did you find care?” 60% of participants mentioned relying on their personal network (friends, family, or support groups) for help with finding a provider, whereas only 35% relied on referrals from their doctor or another mental health provider. A few noted that, without their network, they would have struggled to find care:

*...if it hadn't been for my mom being a therapist herself, I don't know if I ever would have found [my therapists]. (Participant 2)*

*I think that Walla Walla is a pretty good community if you have a network that can guide you. If you are new to the community it is a very sort of insular and in a way cliquish community, so it really requires a network of other citizens to take optimal advantage of what's available. (Participant 11)*

### **1b. Mental Health Literacy Matters**

For some, knowledge barriers interfered with their access to care before they began seeking out treatment. Several participants did not initially recognize their experiences as symptoms of mental illness and did not seek out mental health care until being urged by friends, family members, or other health care providers. Two participants did not know that they needed mental health care until they underwent psychiatric exams that were required by their intended education or career programs.

After recognizing a problem with their mental health, participants often turned first to their general doctors for guidance. Yet many participants felt that their primary care physicians (PCPs) or other doctors did not know how to help them with their mental

health (see Delivery Barriers for more). Similarly, a few others mentioned feeling responsible for recognizing and articulating their mental health needs with doctors, regardless of their own mental health literacy. One participant described the challenge of trying to self-advocate with their doctor when both parties lacked expertise about mental illness:

*...it's easier to advocate for myself when I have a sinus infection versus saying something isn't right with my head...it's harder to know what I need let alone ask for it. (Participant 18)*

Conversely, those with high mental health literacy noted its positive impact on their ability to find care:

*I knew where to look [for therapists], and I knew it well before I got to the county. I took the Mental Health First Aid training also; I think that was helpful to know what is available to people in the area. (Participant 14)*

## **2. Attitude Barriers**

Participants' attitudes about mental illness and treatment played a less significant role in their ongoing ability to access care than other types of barriers. Slightly over half of participants reported that stigma did not currently impede their ability to access treatment. Many felt that mental health had become less stigmatized in recent years, although a few noted persistent stigma for serious mental illness. Nevertheless, stigma impacted many participants early in their experience of mental illness and led many to initially delay seeking out mental health care. Others discussed how living in a small

community magnified the impact of stigma and mentioned the need for more conversations about mental health at the community level. Skepticism over the efficacy of treatment did not emerge as a major trend.

## **2a. Delaying Care**

Many participants experienced feelings of fear, shame, or embarrassment when they began to struggle with their mental health. These negative emotions related to stigma prolonged the amount of time it took for participants to initially seek out treatment. Most participants who put off seeking treatment did so because they did not want to admit that they had a mental health condition, or because they felt unable to discuss their mental health with friends or family:

*I should've been seeing a therapist since I was 13; I was too scared to tell my parents...I had to get over that hurdle...I was pretty embarrassed about it for a really long time... (Participant 1)*

Stigma also made participants more averse to specific types of treatment, especially psychiatric medication. Several initially avoided taking medication because they were not ready to accept that they needed it:

*I think more than anything, [stigma] was around the sense that I should be able to manage this...the idea of needing meds for that was something I struggled with. (Participant 19)*

*I definitely felt like, I don't know, like I shouldn't need medication, that it was an admission of not being functional...there definitely was some degree to which I*

*didn't feel like I could admit to myself or other people that I needed that kind of help. (Participant 18)*

*...at first, I didn't want to [take medication] because of the stigma, I said I didn't need this... (Participant 17)*

## **2b. Stigma in a Small Community**

Some participants found it highly difficult to be open about their mental health while also maintaining privacy in a small community where networks are highly interconnected. A few had delayed care out of fear that people they knew would see them entering a therapist's office and judge them negatively. Those in public-facing lines of work were especially worried about stigma within the community:

*When I graduated...I was a youth pastor in town. The stigma of our kids are trusted with this [person] who has mental health problems was really scary and hard to deal with. (Participant 12)*

*...any admission that I have mental health issues of any sort could undermine my ability to find clients. (Participant 18)*

A few noted the unique ways that stigma manifested itself within specific subgroups of the community. For example, one participant talked about how they had felt stigmatized by their religious community:

*There was a lot of the idea of being suicidal is sinning. It all played a part in me being scared to reach out for help. (Participant 6)*

### **3. Insurance & Price Barriers**

The vast majority of participants considered the sticker price of mental health services to be prohibitively expensive, and health insurance played a critical role in mitigating the cost of care. However, health insurance introduced new challenges, and the extent of both insurance and price barriers depended greatly on whether participants had public or private insurance. Participants across all insurance types noted that their options for providers were limited by their insurance's network. Yet for all publicly insured participants, out-of-pocket costs for covered services were low or zero, and mental health coverage was extensive. Conversely, the quality of coverage and resulting out-of-pocket costs varied greatly among participants with private insurance. Several noted that the burden of frequent co-pays and high deductibles led them to delay or decrease the frequency of care. The few who had used out-of-network services expressed frustration over time-consuming, complicated reimbursement procedures.

#### **3a. Restricted Provider Options**

Because of the high cost of uncovered services, nearly all participants stated that they would only use mental health providers who were covered by their insurance. Limiting the search to covered providers meant that participants' options for affordable care depended greatly on the breadth of their insurance provider's network. Some complained about having to pass over out-of-network providers that would have been a good fit, and some found themselves with few or no local options:

*There have been certain doctors or therapists that I would've loved to have seen that didn't take my insurance. (Participant 2)*

*No one I've ever seen has had insurance. So, I have cancelled numerous times for cost issues. (Participant 12)*

*The first thing I did was I went to my insurance company's website to find out who was covered. Cost was very important to me; I wasn't in a position to just pick someone...I found a short list. (Participant 20)*

Participants with Medicaid faced slightly different restrictions: they could easily access the various providers at Comprehensive Healthcare, but those who wanted to pursue other options found few private practitioners who accepted public insurance:

*I'm state insurance...it's very limited what is open to me and what I have access to. That's why a lot of people go to Comprehensive. If I was a private pay, I think it would be completely different; I have a friend who has private pay and she loves her counselor and she was able to shop around which isn't really an option for state paying. (Participant 15)*

### **3b. Private Insurance: Inconsistent Coverage, Inconsistent Costs**

Privately insured participants noted that the degree of mental health coverage, breadth of provider networks, and out-of-pocket costs varied greatly depending on the plans offered by their employer at any given time:

*When I first sought out services, I worked somewhere else, and I had one of those*



*high deductible plans, and it was awful. A lot of people would accept it, but the out-of-pocket was crazy. (Participant 20)*

Even those who were satisfied with their current plan discussed the importance of having ‘good insurance,’ in order to keep the cost of care manageable. Unfortunately, good insurance was not universally available; a few participants’ employers provided plans that restricted their number of covered counseling appointments to as few as three sessions per year. And, regardless of the generosity of their insurance plan, most participants still had co-pays for all of their appointments. Several noted that the cost of co-pays for frequently scheduled mental health services quickly added up and caused financial stress. Concern over costs often guided decisions about service use, and multiple participants felt the need to decrease their service use in order to lower costs:

*I would have been in treatment ages ago continually if I didn’t have the co-pay. I had gone to a woman earlier and they accepted my insurance, but it was like a \$50 co-pay, so I was like there’s no way. (Participant 8)*

*...there are times in my life where I’ve gone from seeing someone weekly—which was probably in my best interest—to seeing someone once or twice a month because of co-pays. (Participant 14)*

*I ended up having a co-pay for every visit, and for a person with anxiety there’s a level of every time I go I have to pay, maybe I can minimize the amount, I said, let’s go every two weeks instead of 1—whether that was a better option for me, I don’t know. (Participant 18)*

## **4. Delivery Barriers**

Even after overcoming every other hurdle, participants still struggled to access quality services where and when they needed them. Low provider availability and long wait times left many without care for months at a time. Regardless of wait times, accessing care amounted to more than simply finding any available provider—participants needed providers who had the training to address their specific mental health needs. Outpatient counseling, although more available than specialist medication management, remained difficult to access for many. Participants also reflected on the highly interpersonal nature of services like talk therapy and stressed the necessity of finding a good fit with mental health providers. For some, finding fit was especially difficult, and the challenge was compounded by other barriers that restricted their options for providers, such as price and insurance. Participants also frequently expressed dissatisfaction with care they had received from prescribers. Many who relied on general practitioners for prescriptive services perceived that they tended to over-prescribe psychiatric medication. Some participants who used private practitioners also complained about a general lack of communication between their prescribers and their other mental health providers. On the other hand, most participants who received services at Comprehensive Healthcare were satisfied with the integration of the various services provided by the organization.

### **4a. Low Availability, High Demand**

Many participants perceived that there were too few local mental health providers to meet the needs of the local population. Several spoke about how low provider availability delayed or limited access to care:

*So many therapists are already booked out...if someone doesn't have any openings [people] are likely to give up. My therapist has told me about how many people she's had to say no to. (Participant 12)*

*...one of the biggest challenges is the wait to get started, it can take sometimes 2-3 months to get into their schedule...you have to wait until they have more openings. (Participant 19)*

*...the prescriber is definitely hard to get a hold of... you have to schedule out—well like I think three months—cause I remember missing an appointment and I had to wait another three months...I think it's just because she's one of the only prescribers here in town. (Participant 16)*

Not everyone experienced long wait times, however. One participant, who did not have to wait to start seeing their provider, attributed the ease of the experience to their personal connections:

*I got in immediately. I believe it was networking more than anything. (Participant 15)*

Some services were more available than others. Participants reported that, within the county, medication management services from PCPs or general doctors was easy to access. Outpatient counseling was more difficult to access, and specialized medication management was the most difficult. The lack of psychiatrists or other specialists drove

multiple participants to seek care in areas outside of the county with higher availability, though not all were able to commute:

*I think probably the hardest thing was you know traveling for a distance, because there was not really anything here in Walla Walla. If it had been farther than Spokane, then I don't know. When you don't know where to go, you go where you can. (Participant 13, Caregiver)*

*The doctor I was seeing at the time had an office at Tri-Cities, he sometimes asked me to drive all the way there. That was really rough because I had no car, so my parents had to help me, and it was stressful. (Participant 2)*

In addition to psychiatrists, participants also spoke about the lack of local providers that specialize in certain conditions, such as eating disorders or serious mental illness. A few also noted that the community lacks providers who are appropriately trained to address the unique needs of specific populations, such as the LGBTQ community.

#### **4b. Finding Fit**

According to most participants, the success of their mental health treatment relied heavily on the degree of 'fit' between them and their providers, especially for counseling services. Yet many noted that in their search for local providers, finding fit was a major challenge:

*Finding a good fit is really hard. I would try to scrape the money together to find someone that could actually help me but when I get in there it never seems to click. (Participant 8)*

*...it's hit and miss. I've had 3 good fits total out of all the people I've seen. It's like looking for a needle in a haystack. (Participant 6)*

Reasons cited for poor fit ranged from egregious issues, such as unprofessional behavior or harassment, to more nuanced problems, such as ideological differences. Notably, multiple participants who used services at Comprehensive Healthcare said that it was easy to switch providers within the agency if there was not a good fit. For some others, though, poor fit led them to stop using services, rather than begin the search for a new provider:

*...there was a lady at the VA that I did not connect with. I just stopped seeing her. I didn't search for another provider, it just kinda left a bad taste in my mouth so I left it alone for a while. (Participant 3)*

To explain what makes a good fit, participants spoke about the qualities they looked for in providers. Though these qualities varied across participants, several participants mentioned at least one of the following traits: nonjudgmental, empathetic, experienced, smart. Participants valued providers who took the time to truly listen to their patients and tailor the treatment to their individual needs:

*...the thing that just impressed me so much was that he was very respectful of his patients, it seemed like he was on equal footing, what the patient was saying really mattered to him. (Participant 13, Caregiver)*

*...I don't need you to fix me, I need you to support me. I need you to really hear me, sometimes if that's just listening without having an answer, then wonderful. I do better if I come to the conclusion myself with you aiding me. (Participant 15)*

Many participants also preferred to see a provider with their same gender.

#### **4c. Problems with Prescribers**

Participants taking psychiatric medication received outpatient medication management services through general doctors/PCPs, private psychiatric NPs, or through specialists at community agencies like the VA or Comprehensive Healthcare. Many reported having had at least one negative experience with a medication management provider. Some felt that their doctors 'pushed pills' at their problems, and wished that they would take a more holistic approach to treating mental health conditions:

*...one of the things I noticed with my PCP back in my mid 20s was that sometimes the ability/propensity to prescribe things but not necessarily do any counseling around the things...here's the pills, take them, rather than, here's the pills and by the way if you google this thing it's labelled as an antipsychotic, which is stressful if you have anxiety... (Participant 19)*

*[I wish] that it wasn't pushed so much that a pill could fix your problem. That you really have the option to build trust with someone, to get to the root and overcome it. (Participant 15)*

Others felt that their doctors did not know enough about mental illness and psychiatric drugs to provide them with adequate care, especially in the case of serious mental illness:

*Medication management in this town is a disaster. Psychopharmacology is an incredibly specialized thing; people have to have a lot of training and know what they're doing. I tend to find that I go in and tell the doctor, hey I need to lower/raise my dose of this, because the doctor doesn't know anything... (Participant 20)*

*My PCP, he was running my meds for me because there was no other option, but he didn't know what he was doing. (Participant 12)*

*My doctor didn't know what to do with bipolar meds... (Participant 6)*

Participants generally reported having more positive experiences with psychiatric NPs or other medication specialists than with PCPs. Still, some reported problems with specialists, ranging from dismissiveness over side effects to inappropriate behavior. For one participant, a dismissive provider had drastic consequences that caused them to discontinue medication use altogether:

*...the experience was so awful that I'm too afraid to take any other medication...he put me on a med that was giving me severe side effects and my mom and me went to see him one time and he just acted like it would get better. I was sleeping almost constantly for 2 weeks and ended up in the ICU. (Participant 2)*



## **Discussion**

In any community, accessing mental health care depends not only on the number of local service providers, but also on the ease of the various intermediate steps that occur between having an unmet mental health need and receiving the right care. These intermediate steps—which include identifying the need, connecting with appropriate providers, and paying for treatment, amongst others—all present potential barriers for people living with mental illness. The present study aimed to identify specific barriers that limit access to mental health care across the population of Walla Walla County based on the lived experiences of county residents. Relatedly, this research also explored possible disparities in access by comparing the experiences of privately and publicly insured residents. Findings, based on interviews with 20 adults who had used local mental health services, revealed a host of barriers that affected residents across sociodemographic groups. Few major differences emerged among privately and publicly insured residents' access to mental health care, although the publicly insured benefitted from more consistent insurance coverage and lower costs of care. Publicly insured residents also had greater access to integrated care through facilities such as Comprehensive Healthcare and the VA Medical Center, yet they had more limited access than privately insured residents to private mental health practitioners.

Taken together, findings from this research demonstrate that access to outpatient mental health care ought to be viewed as a long-term, continuous process, rather than as a singular event. First-hand accounts from Walla Walla County residents point to the ever-changing nature of access, which appears to fluctuate along a spectrum. Consistent with the findings by Health Care for All, county residents' level of access varied according to

several factors, including but not limited to: knowledge and attitudes mental illness; knowledge about mental health care systems; insurance coverage and out-of-pocket costs for mental health services; and the efficacy and coordination of primary and specialty health care delivery systems (Health Care for All, 2017). Most residents' access to care was limited by more than one type of barrier, and their experiences reflect how barriers across conceptual categories (knowledge, attitude, delivery, price, and insurance) interact to greatly impede access. The following anecdote, which is a composite of several interviewees' experiences, illustrates how the process of accessing care becomes increasingly difficult and long-lasting as barriers accumulate. Parentheticals are used to denote relevant barrier themes and subthemes from the results section:

A Walla Walla County resident experiences significant anxiety for years before realizing that their symptoms may be a sign of mental illness (knowledge barriers: mental health literacy matters). Even after they recognize the significance of their symptoms, they hesitate to ask for help because they feel ashamed about needing mental health care (attitude barriers: delayed care). When they finally decide to seek care, they turn to their PCP, who prescribes them an anti-anxiety medication but offers little other guidance (delivery barriers: problems with prescribers). Worried about side effects and other consequences of medication, they decide to try to manage their anxiety on their own. Eventually, they experience a panic attack, which prompts them to search again for mental health care. This time, they search online for local therapists, but are confused by the provider terminology and struggle to understand what type of care they should be looking for (knowledge barriers: problems with the provider search). Because they cannot

afford the high cost of out-of-network care, they only look for providers who take their insurance, and find a short list of covered providers that seem appropriate for their needs (insurance & price barriers: restricted provider options). They call each provider and learn that most of them are not currently accepting new patients (delivery barriers: low availability, high demand). Finally, they find an available provider. They go in for a few appointments, but do not connect well with the provider, and feel they are not benefiting from their sessions (delivery barriers: finding fit). Discouraged and overwhelmed, they stop seeing the provider, and do not seek other treatment.

This example sheds light on how the predominant modes of delivering mental health care, which are typically more reactive than proactive, can place undue burdens on people living with mental illness. These burdens caused many county residents to delay or avoid seeking mental health care until their symptoms reached a crisis level, at which point they were especially ill-equipped to jump through hoops to access care. Efforts to improve countywide mental health will not succeed without interventions to mitigate barriers that limit timely access to mental health care for all county residents.

## **Limitations & Future Directions**

Despite covering a wide scope of barriers, this research does not account for all of the problems that affect access to care in Walla Walla County, and the results should be interpreted with several limitations in mind. First, this study is primarily limited by the demographic makeup of its participants, the majority of whom were non-Latinx white women. Though attempts to reach Spanish-speaking populations were made during recruitment, these were largely unsuccessful. Challenges like language barriers and lack

of culturally competent care—which disproportionately affect minority populations—were not reported by participants in this sample. However, given that about 1/5 of Walla Walla County residents are Latinx and another 10% belong to other racial or ethnic minority groups, it can be reasonably expected that these types of barriers exist within the community and ought to be addressed.

Second, participants also overwhelmingly hailed from the county’s metropolitan area. Those living in the county’s rural towns were not represented in this sample, and they likely face unique barriers related to the especially small size of their communities and increased distance from most of the county’s mental health resources (which are concentrated in Walla Walla and College Place). Future countywide research efforts should be spearheaded by community members who represent both the racial and geographic diversity of Walla Walla County and are thus better equipped to access all of its subpopulations. Third, findings from this research may have underrepresented the impact of stigma due to selection bias, given that community members who feel less stigmatized about their mental illness are likely to be more willing to openly discuss their mental health with a researcher.

Understanding community-wide mental health needs requires frequent reevaluation to keep up with how changes to public policy, social norms, and community resources impact access to care. County leaders are encouraged to continue engaging in this evaluative process on an ongoing basis by soliciting input from community members who use local mental health services. Though the current research focused primarily on outpatient mental health care access for adults, future studies can build upon these findings by evaluating access to care among youths, access to inpatient services, and

access to services for substance use disorders, which have high comorbidity with various mental health disorders (Lai, Cleary, Sitharthan, & Hunt, 2015). Additionally, while the perspective of health care consumers is invaluable, wholly informed policy decisions meant to improve access to mental health care should also weigh input from health care providers. Future researchers can build upon this study by engaging with community members who have direct knowledge of both general health care and mental health care delivery systems. PCPs, psychiatric NPs, outpatient therapists, and crisis workers all have invaluable perspectives to contribute to conversations about problems with access to mental health care in Walla Walla County and potential solutions.

## **Recommendations**

Findings from this research are intended to help local leaders and health care providers in Walla Walla County improve local access to mental health care by responding to identified areas of need. As reported in the results section, the 9 sub-themes gathered from interviews with residents highlight such areas of need by providing examples of specific barriers they faced while trying to access care. However, not all barriers can be alleviated to the same extent with a response at local level. The following recommendations are thus meant to reflect local jurisdiction and provide actionable items for local mental health care providers, doctors, and county leaders.

### **Recommendations for Mental Health Care Providers**

1. Outpatient providers who operate a private practice should make a concerted effort to join and promote existing online resource directories, such as the Mental Health Network of Walla Walla. Expanding these networks, where lists of providers are

available in one place, greatly eases the burden of the provider search for consumers. Providers should ensure that their profiles both on shared resource directories and on their personal sites contain up-to-date information about their availability, costs, and accepted forms of health insurance (see theme 1a., Problems with the Provider Search).

2. Outpatient counselors and therapists should offer no-cost intake sessions of some form (even if brief) so that potential clients can test ‘fit.’ In addition, providers should consider methods of collecting anonymous feedback from past or current clients so that they can continuously evaluate the efficacy of their treatment approaches and make any necessary improvements (see theme 4b., Finding Fit).
3. Though mental health providers cannot reasonably be held entirely responsible for lowering the cost of care, providers can make certain adjustments to render their care more accessible to people of all income levels. Providers who do not accept insurance should consider employing a sliding-scale fee structure or setting aside a number of pro-bono spots to ensure that their services are affordable for a larger percentage of the population. Those who do accept insurance should strive to be equally accessible to those with private and public insurance. Providers who do not already do so should consider paneling with Medicaid and Medicare (see theme 3a., Restricted Provider Options).

### **Recommendations for Doctors (PCPs and other generalists)**

1. Primary care physicians should promote and strive toward better integration of behavioral health care into primary care settings, especially because many participants obtained all or most of their health care through PCPs. Doctors should

assume responsibility for monitoring their patients' mental health just as they would with their physical health. Doctors can ensure timely diagnosis of mental health conditions by regularly administering screening tools (such as the PHQ-9) to their patients, so that the burden of recognizing symptoms of mental illness does not fall on patients or their loved ones. Doctors who are generalists by nature should not be held responsible for developing extensive expertise in mental illness; however, doctors must also be aware of the limitations of their knowledge so that they can refer patients to appropriate channels when more expertise is needed (see 1b., Mental Health Literacy Matters).

2. Doctors, who often only provide mental health care through prescriptive services, should take steps to address patient mental health more holistically. Though medication is a critically important aspect of mental health care for many individuals, it should not be the only line of treatment advised by doctors. Doctors can and should steer patients toward other forms of mental health care, including psychotherapy and support groups. When prescriptive services are necessary, doctors should take time to fully address their patient's questions, reservations, and fears surrounding psychiatric medication, given the impact of doctor-patient communication on medicated treatment adherence (Mitchell, 2006). Prescribing doctors should also refer patients toward other forms of treatment, namely psychotherapy, in conjunction with medication to improve outcomes (see 4c., Problems with Prescribers).

**Recommendations for County Leaders (county officials, heads of local organizations)**

1. Because of the wide variety in mental health literacy among community members, county leaders and public health officials should assume some responsibility for educating county residents on basic symptoms of common mental illness such as depression or anxiety. Improved education will help prepare all community members to recognize symptoms in themselves or their loved ones and find appropriate care. In addition, county leaders can also provide guidance to community members who are struggling to access mental health care. For example, county leaders can maintain an up-to-date resource guide, complete with a list of local low or no-cost mental health services (see 1a., Problems with the Provider Search; and 1b., Mental Health Literacy Matters).
2. County officials should embark on stigma-reducing campaigns in partnership with community leaders of organizations, including schools and universities, religious groups, and nonprofits. Cross-sector partnerships can broaden the reach of stigma-reducing efforts across the community. County leaders can partner with other organizations to host public events, such as film screenings and behavioral health town halls with expert panels to promote positive, community wide conversations about mental health (see 1b., Mental Health Literacy Matters; 2b., Delayed Care; and 2c., Stigma in a Small Community).



## Appendix A: Interview Outline

1. To start off, would you tell me about what kind of mental health treatments you have accessed (or tried to access) in the county?
  - a. Are the services you used related to a particular mental health condition or diagnosis?
2. What, if anything, prevented you from looking for care that you needed? If you were looking for care, did anything make it difficult to get?
  - a. [if answers include insurance/costs]: You mentioned the cost. Could you elaborate on this? Also, could you indicate if you receive insurance through Apple Health, Medicare, or a private plan like Blue Cross Blue Shield?
  - b. [if answers include stigma or privacy concerns]: You mentioned fear of what family/friends would think. Could you tell me more?
3. Think back to a time when either you or a family member needed care for mental health. I'd like to hear about your experience of trying to find care. Who recommended that you get care?
  - a. How did you find care? Did you go online? Call your insurance? Speak with your primary care provider?
  - b. What makes a good fit in finding a provider (like a therapist, psychiatrist, etc.)? What do or did you look for?
    - i. Has it been possible to find providers with these qualities locally?

- c. If you have used multiple mental health services, were some easier than others to access? If yes, which ones?
      - i. What made some services more difficult to access?
    - d. How do your experiences with access to mental health services compare to your experiences with physical health services (like getting a checkup with your primary care doctor or a vaccination)?
- 4. I'd like to hear a little more about you/your family member's experience getting a service covered/paid for by your health insurance plan whether Apple Health, Medicare, private plans, or no insurance. After you tried to find care, what was your interaction with your insurance company?
  - a. Did you have problems getting services covered? If yes, what did you do about it?
  - b. Were you able to choose your insurance plan? If yes, what, if anything, influenced your choice in health plans?
  - c. Would you be able or willing to pay for out-of-network services?
  - d. What (if any) are your typical out-of-pocket costs for care? Co-pays? Deductibles?
- 5. Do you have any suggestions for how access to local mental health care services might be improved?
- 6. Are there any other issues you've faced related to accessing mental health care that you would like to add?

## Appendix B: Recruitment Materials



WHITMAN  
COLLEGE

### RESEARCH PARTICIPANTS WANTED

.....

**HAVE YOU OR SOMEONE YOU  
CARE FOR USED ANY LOCAL  
MENTAL HEALTH CARE SERVICES?**

#### **YOUR VOICE MATTERS!**

We want to hear about your experience with accessing mental health care. Were you able to get the care you need within Walla Walla County?

Participate in a 30-minute interview about your experience to help the Department of Community Health learn more about local access to care. You will receive **\$30** for your time.

Registration is **required**.

Email Sara at [federmsj@whitman.edu](mailto:federmsj@whitman.edu) with the subject line "Research Study" if you would like to register.

*All information will be kept confidential. Interviews will be in English, with Spanish translation services available. You must be 18 or older and a Walla Walla County resident to participate.*



## SE BUSCA: PARTICIPANTES DE INVESTIGACIÓN

WHITMAN  
COLLEGE

### ¿USTED O ALGUIEN QUE CUIDA HA UTILIZADO SERVICIOS LOCALES DE ATENCIÓN DE SALUD MENTAL?

#### ¡SU VOZ IMPORTA!

Queremos enterarse de su experiencia con el acceso a servicios de salud mental. ¿Pudiste recibir la atención que necesitaba en el condado de Walla Walla?

Participe en una entrevista para ayudar el Departamento de Salud Comunitaria. La entrevista será 30 minutos sobre su experiencia y recibirá **\$30** para su tiempo.

La inscripción es **requerido**.

Si desea registrarse, envíe un correo electrónico con la línea asunto "El estudio de investigación" o "Research Study" a Sara al [federmsj@whitman.edu](mailto:federmsj@whitman.edu).

*Toda la información del estudio se mantendrá confidencial. Las entrevistas estarán en inglés con servicios de traducción al español. Para participar usted debe ser por lo menos 18 años de edad y un residente del condado de Walla Walla.*

## Appendix C: Theme & Sub-theme Frequencies

*Frequency of Themes and Subthemes Identified in Interviews*

Themes and subthemes	Percentage (n) of participants who mentioned the theme
<b>Knowledge barriers</b>	70% (14)
Problems with the provider search	65% (13)
Mental health literacy matters	40% (8)
<b>Attitude barriers</b>	60% (12)
Delaying care	50% (10)
Stigma in a small community	25% (5)
<b>Insurance &amp; price barriers</b>	90% (18)
Restricted provider options	90% (18)
Private insurance: inconsistent coverage, inconsistent costs	89% <sup>a</sup> (8)
<b>Delivery barriers</b>	90% (18)
Low availability, high demand	70% (14)
Finding fit	70% (14)
Problems with prescribers	60% (12)

<sup>a</sup> Calculation reflects the total number of privately insured participants (9).

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