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The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston

To the Editor:

Mental health disorders are common, affecting nearly 1 in 4 adults annually.[1] Unfortunately, less than a third will receive services within a year.[2] Inadequate treatment results in individual and family suffering, lost productivity, and death: suicide, the third leading cause of death among individuals aged 10 to 24 years, is associated with inadequate care.

As Massachusetts clinicians caring for patients with mental illness, we experience frequent difficulties obtaining psychiatric care for our patients. But how bad are things, really? To find out, we conducted a “simulated patient” study, with the approval of the CHA institutional review board.

Study personnel posed as patients insured by Blue Cross Blue Shield of Massachusetts PPO, the largest insurer in Massachusetts. We called every in-network mental health facility within a 10-mile radius of downtown Boston, claiming that we had been evaluated in an emergency department (ED) for depression and discharged with instruction to obtain a psychiatric appointment within 2 weeks. If necessary, we left a message and made a second call attempt.

Eight (12.5%) of the 64 sites offered appointments, 4 (6.2%) within 2 weeks (Table). The 2 principal reasons we could not schedule an appointment were that our calls were not returned or that the facility required patients to have an in-system primary care provider. Six sites stated that they needed more information before scheduling an appointment. Assuming these 6 sites would have offered timely appointments, our highest estimate of available appointments within the 2-week period is 10 of 64 facilities (15.6%).

This result confirms our suspicion that even for patients with private insurance, mental health services in the Boston area are severely limited, which is in line with national data showing limited availability; for example, two thirds of primary care physicians report that they cannot obtain outpatient mental health services for patients who need them.[3]

Our inadequate mental health system has widespread social effects. A third of the homeless and more than half of all prison and jail inmates have mental illness.[1] The nation’s EDs are de facto psychiatric wards, with 79% of emergency physicians reporting that their hospitals board psychiatric patients for whom appropriate treatment resources could not be found, sometimes for days.[4]

Although there are many contributors to the inadequacy of our mental health system, managed care has hit psychiatric services hard. Private insurers aggressively constrain patients’ access to services by stringently limiting provider networks. As our study shows, this is often covert; insurers provide lists of in-network providers, but most are unavailable. Reimbursements for psychiatric services are far lower than for other types of care, so institutions frequently restrict access as stringently as possible, often, as in our study, by requiring that a patient have an in-system primary care provider (even though the insurer requires no referral). Many private practitioners refuse to accept insurance payments altogether. Improved reimbursements for psychiatric care will be an important step in reducing the barriers to care experienced by patients with severe depression.

Table. Provider response to a request for an outpatient psychiatric appointment for depression.

Response	Number of BCBS-PPO Providers (%), N=64
Appointment granted within 2 wk	4 (6.3)
Appointment granted after 2 wk	4 (6.3)
No appointment granted without a PCP within their system	15 (23.4)
No return call despite leaving 2 messages	15 (23.4)
No psychiatrist available/cutbacks	8 (12.5)
Youth/specialty services only	6 (9.4)
Required more or specific information	6 (9.4)
Didn’t accept insurance	1 (1.6)
Only group treatment offered	1 (1.6)
No reason given	4 (7.1)

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1. National Institute of Mental Health. The numbers count: mental disorders in America. 2010. Available at: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#MajorDepressive. Accessed October 8, 2010.

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2. Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med*. 2005;352: 2515-2523.
3. Cunningham P. Beyond parity: primary care physicians' perspectives on access to mental health care. *Health Aff (Millwood)*. 2009;28:w490-w501.
4. American College of Emergency Physicians. *ACEP Psychiatric and Substance Abuse Survey 2008*. Irving, TX: American College of Emergency Physicians; 2008. Available at: http://www.acep.org/uploadedfiles/ACEP/Advocacy/federal_issues/PsychiatricBoardingSummary.pdf. Accessed September 26, 2010.

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