Education Research Statistics Descriptive and Comparative

Economics and Mental Health Services

Cheri Trahan Keene

The University of Texas at San Antonio

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Stigma for those with mental illnesses occurs on many levels, from social and institutional to individual and self. Stigma undermines the individual’s sense of self and independence (Corrigan, 2004). Individuals struggle to make social contact as they view themselves as less worthy of friendship (Corrigan, 2004). They struggle to find housing that is adequate and safe, to find employment that provides them with a livable income, and to have access to and care for their children (Corrigan, 2004). Economic disadvantage and underinsurance often increase barriers to mental health treatment for persons with serious mental illness, compounding the stigma of mental illness and its effects (Evans et al., n.d.).

Corrigan & Watson (2004) described the process of stigmatization as involving awareness of cues which include psychiatric symptoms, social-skill deficits, physical appearance, and labels, stereotypes, and the development of prejudice and discrimination. Link and Phelan (2001) found that stigma arose when labels were created, undesirable characteristics were linked to the labeled individuals, and distinct categories created “us” and “them” groups. The labeled individuals then experienced unequal outcomes as a result of status loss and discrimination created by the power differential that existed between the us and them groups (Link & Phelan, 2001). Economic disadvantage contributes to the loss of status and the discrimination resulting from the power differential between the us and them groups. Roberts (2005) shed light on the power differential that existed within the mental health care structure by introducing Foucault’s idea that expert knowledge allowed the practitioner to hold a power which could impede the therapeutic process by creating stigma for the client.

According to the World Health Organization (WHO) World Mental Health (WMH) survey, the family income of a person diagnosed with mental illness had a positive correlation to treatment, specifically specialist mental health (SMH) treatment for those with more serious diagnoses (Evans et al., n.d.). The WMH survey also concluded that people with fewer financial resources have a lower rate of treatment especially SMH treatment (Evans et al., n.d.). Financial resources were not the only factor impacting access to mental health care. Access to medical insurance also affects the client’s ability to receive appropriate care. Walker, Cummings, Hockenberry, & Druss, (n.d.) determined that individuals with mental illnesses were less likely than those without mental illnesses to have medical insurance and were more likely to receive Medicaid benefits (Walker et al., n.d.). At times, it seems that access to mental health care is improving for those who are economically disadvantaged. For instance, in October 2008, the US congress signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAE) creating greater access and fewer barriers to health insurance coverage for mental health issues (Barry, Huskamp, & Goldman, 2010). In 2010, the Affordable Care Act identified mental health as an essential health benefit, and progress continued to be made through 2014 as other provisions of mental health parity were implemented (Bartlett, & Manderscheid, 2016). However, President Donald Trump’s executive order in January 2017 served to derail the progress previously made (McCarthy, 2017).

Walker et al (n.d.) concluded that improving access requires addressing barriers including cost of medical care, lack of insurance as well as attitudes toward mental illness and its care. Once the individual enters the mental health care system, protections against stigmatization need to be in place to insure quality of care as well (Walker et al., n.d.). In light of these findings, data analysis of the 2015 National Mental Health Services survey hopes to answer the following regarding the relationship of sliding fee scale, an indicator of the SES group served, and services provided:

1. Do treatment facilities which offer sliding fee scale offer a more limited range of services?

2. Does level of care offered vary with sliding fee scale?

3. Do treatment facilities which offer sliding fee scale offer fewer treatment modalities?

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