

ORIGINAL ARTICLE

Access to care barriers for patients with Bipolar disorder in the United States



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KEYWORDS

Bipolar disorder;
Access to mental
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Abstract

Background: The five major comorbidities associated with Bipolar Disorder (BPD) include anxiety disorder, substance abuse, attention deficit hyperactivity disorder, personality disorder, and other medical conditions. These conditions are extremely prevalent among patients with BPD. Additionally, the medications used to treat this disorder can cause severe weight gain, which leads to cardiovascular disease, type 2 diabetes, and other endocrine disorders.

Purpose: The purpose of this paper is to inform the medical community and health policymakers of the causes and comorbidities associated with BPD; stigma, acceptance of insurance, shortage of providers and costs as barriers to access care; and the collaborative care model and policy-based solutions to improve the access to high quality care and the quality of life of people living with bipolar disorder.

Results: Recent policy developments that address mental health in the United States, such as, the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Helping Families in Mental Health Crisis Act are opportunities to improve access to care. Though not specifically targeting BPD, collaborative programs and mental health policies can start monitoring the comorbidities associated with BPD. By focusing on prevention and collaborative care, providers can slow the acceleration of symptoms and allow for quicker channels of treatment for comorbidities.

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PALABRAS CLAVE

Trastorno bipolar;
Acceso a los servicios
de salud mental;
Organizaciones de
atención responsable;

Barreras de acceso a la atención médica para los pacientes con trastorno bipolar en Estados Unidos

Resumen

Antecedentes: Las personas con trastorno bipolar generalmente tienen otros padecimientos (comorbilidad) como son los trastornos de ansiedad, el consumo de alcohol y drogas, el déficit de atención e hiperactividad, y los trastornos de la personalidad, además de otras enfermedades; la prevalencia de la comorbilidad es alta. Adicionalmente, los medicamentos para el tratamiento

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Modelo de atención crónica; Comorbilidades bipolares

del trastorno bipolar contribuyen al incremento de la masa muscular aumentando de manera importante el riesgo para la aparición de enfermedad cardiovascular, diabetes mellitus tipo II y otras enfermedades endocrinas.

Propósito: Informar a la comunidad médica y a los responsables de las políticas de salud sobre las causas, las comorbilidades asociadas al trastorno bipolar y las barreras de acceso a los servicios de salud que provocan el estigma, la aceptación de los seguros, la escasez de proveedores y los altos costos. La adopción de modelos de atención colaborativa y de políticas que facilitan el acceso a los servicios de salud de alta calidad pueden mejorar la calidad de vida de las personas con trastorno bipolar.

Resultados: Nuevas leyes de salud mental en Estados Unidos como la de mejora de la equidad de los servicios de salud mental y contra las adicciones (Mental Health Parity and Addiction Equity Act [MHPAEA]) y la de ayuda a las familias en crisis por problemas de salud mental (Helping Families in Mental Health Crisis Act) son oportunidades para mejorar el acceso a los servicios de salud mental en general. En el contexto de las nuevas políticas públicas y el desarrollo de programas de salud mental con un modelo de atención colaborativa deben facilitar la disponibilidad de servicios de prevención y para la monitoria de las comorbilidades asociadas al trastorno bipolar contribuyendo a manejo de los síntomas y facilitando el acceso a canales para el tratamiento de las comorbilidades.

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Introduction

In 2016, approximately 1 in 5 adults had a mental health illness in the United States, which equates to an estimated 44.7 million individuals.²⁰ Mental health conditions were found to be more prevalent among women, young to middle-aged adults (18–49 years old), and individuals identifying as American Indian or Alaskan Native or having two or more races or ethnicities.²⁰ Furthermore, women, children and working-age adults, uninsured, low income, and Latinos (compared to non-Latinos), were significantly more likely to report having an unmet mental health need.²⁹

More specifically, 2.8% of adults living in the United States have been diagnosed with bipolar disorder (BPD).²¹ Bipolar disorder is found equally among men and women, but significantly higher percentages are found among young adults ages 18–29 compared to older adults.²¹ Furthermore, of those diagnosed with BPD, 82.9% report serious impairments, with mood disorders reported as the most prevalent impairment.²¹

Bipolar disorder is a brain disorder that causes extreme fluctuations with mood and is commonly referred to as a manic-depressive illness. There are four main types of BPD: bipolar I disorder, bipolar II disorder, cyclothymic disorder, and other specified and unspecified bipolar-related disorders. Signs that can be associated with BPD follow two very different sets of symptoms, which is what distinguishes it from other mental illnesses. These illnesses can show periods of mania, which can include, but are not limited to, extreme mood swings, increased activity, and unusual risk taking. There are also signs of depression during times when mania is not present, which can present feelings of sadness and emptiness, lack of energy, trouble sleeping, and thoughts of death and even suicide. People with BPD can also have a multitude of comorbidities, including anxiety,

substance abuse, attention deficit hyperactivity disorder (ADHD), personality disorders, and common medical conditions. These comorbidities have direct relationship with other health issues that are compounded on top of the disease itself.

Anxiety

Anxiety disorders are the most prevalent comorbidities to BPD with a lifetime prevalence of 45%.²⁶ Additionally, one in two individuals with BPD has some type of anxiety disorder in their lifetime.^{26,34} Anxiety is marked by feelings of uneasiness, irritability and fatigue. Anxiety can lead to other problems including common phobias, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and panic disorders. These comorbidities of BPD can lead to symptoms like suicidal thoughts, psychotic incidents, and substance abuse. Aside from its high prevalence and compounding additional health problems, anxiety disorder can adversely affect a patient's diagnosis and treatment of BPD.³⁴

Substance abuse

Substance abuse is another comorbidity commonly found among patients with BPD; in fact, approximately 55% of patients with BPD are inflicted with a substance abuse disorder.¹⁴ Further analysis indicates that the most prevalent substance was alcohol (25–30%) followed by cannabis (20%) and cocaine, amphetamines, and opiates (10–15%).¹⁴ Substance abuse has been found to be more common in men than women with lifetime prevalence of approximately 51% and 34%, respectively.¹⁴ Another study dichotomized the main types of substance abuse among patients with BPD

and found that males with BPD also experienced drug abuse (51%) and alcohol abuse (29%), respectively.²⁵ There is no biological evidence that is available to explain why substance abuse is higher among men. To date, there is only one main explanation that can be made for why there is such a high correlation between substance abuse and BPD. Patients with BPD have no control over their cycles of mania and depression that can be a part of their lives. The one thing that patients can control is the substances that they use. Mental illness is another key indicator for substance abuse, but the need for control can be more strongly associated with BPD.

Attention deficit hyperactivity disorder

Research has found that 6–20% of adults with BPD were also diagnosed with ADHD.^{33,35} Approximately 16% of adults have diagnosed ADHD. Ryden et al.³⁰ found that adults with BPD and ADHD experienced their first psychiatric symptom and affective episode compared to adults with only BPD. Furthermore, these adults experience more hypomanic, total affective episodes, suicide attempts and violent incidents.³⁰ Adults who experienced ADHD only in childhood had comparable results regarding timing of their psychiatric symptoms and affective episodes; however, the results of the remaining incidents were varied.³⁰

Personality disorders

Personality disorders can be more difficult to diagnose when associated with patients who are suffering from both. The effects that both disorders have on the mood may overlap. Most personality disorders cannot be treated, until the symptoms from BPD are managed. Research has found that 17–38% of patients with BPD were diagnosed with a personality disorder.^{4,25} However, it is challenging to calculate the percentage of patients with BPD and a personality disorder because of its rarity and diagnostic difficulty.

Medical conditions

Medical conditions are something that affect all the lives of those with BPD because of the weight gain that is associated with this disease. The medications used to treat this disorder can cause severe weight gain, which lead to cardiovascular disease, type 2 diabetes, and different types of endocrine disorders.³² One study found that obesity patients with BPD were significantly more likely to receive medication, seek treatment, be hospitalized, and present to the ED for depression compared to non-obese patients with BPD.¹⁰ Moreover, obesity was linked to more depressive and manic episodes.^{8,10} Finally, obesity as a comorbidity of BPD can lead to further discrimination and stigmatization and can negatively impact physical well-being, quality of life,^{9,17} self-esteem, and sleep cycles.⁶

Treatment options

There are various treatment options used for BPD.³¹ discuss the best options for treating BPD, including medications,

psychotherapy, and electroconvulsive therapy (ECT). When it comes to medication there is a general consensus that mood stabilizers are the most effective form of treatment during all phases of the illness, of which, Divalproex and lithium are the most common medication choices. Carbamazepine is the leading alternative to these two medications. These can be used as a form of monotherapy, which is receiving treatment from only one medication. If monotherapy is unsuccessful then there is a suggestion to use multiple medications since patients who have severe depression often need a combination of mood stabilizers and antidepressants. Patients who have depression or mania with symptoms of psychosis use antipsychotics. Additionally, there are a couple of forms of therapy that can be used, including cognitive therapy, family focused therapy, interpersonal and social rhythm therapy, and psychoeducation. Electroconvulsive therapy is used in very severe cases of BPD but is not the most common form of treatment and raises the most ethical questions. With all these treatments that are offered, it seems that medications may be doing more harm physically; while they stabilize patients' moods and feelings, there are a lot of physical ramifications that come with taking these medications. Obesity has affected nearly 75% of bipolar patients due not only to the phases of depression but the side effects of.³⁶ Prolonged use of lithium can also lead to problems with a patient's metabolism. There needs to be a better way to treat the mental and physical health of bipolar patients.

Problems

Based on the severity of BPD and the high rates of comorbid conditions associated with BPD, what factors are inhibiting patients with BPD from receiving the highest quality of care? What is being done to counteract these overwhelming and alarming statistics? Once we have an understanding of the factors inhibiting access to care for patients with BPD, targeted policies and programs can be formulated and implemented with the overall goals of improving access to high-quality care and quality of life¹ discuss how the physical and mental health of bipolar patients are affected by the disorder. Patients with BPD with additional health problems express low quality of life resulting from the limitations that surround day to day activities. Continuous body pain was associated with symptoms of mania and showed increasing severity of BPD and more severe mood symptoms over time. This shows that insufficient care can lead to many physical problems. Aside from the physical problems, additional mental health concerns are often prevalent among patients with BPD. Discouragingly, the rate of suicide among this patient population in the United States is 0.4%, 20 times greater than the general population.¹⁶ The focus needs to be on monitoring the illness to catch a comorbidity early, which is critical to improved quality of life. However, there are numerous access to care barriers for patients with BPD including, stigma associated with a mental health condition, insurance acceptance rates, and mental health provider shortages. Another major problem, which may also serve as an access to care barrier, is the cost of care. Each of these problems will be addressed in the subsequent sections.

Stigma

Stigma is a serious problem surrounding the entirety of mental health care. Stigma can be found among patients, family members, larger social environments, occupational or educational environments, and healthcare settings.¹³ Stigma is associated with a loss of social support, occupational success, overall functioning, and quality of life.¹³ Stigma can also extend beyond the patient to caregivers as well and can lead to the presence of depressive symptoms and avoidance coping.²⁷ A parallel construct to stigma is cultural influence and acceptance of mental health concerns. A person's cultural values may influence his/her reluctance to seek mental health treatment, and therefore serve as a barrier to seeking care.^{3,19}

Insurance coverage

Research shows the percentage of psychiatrists who accept health insurance (private, Medicare, or Medicaid) is significantly lower than the percentage accepted by other health professionals.² Furthermore, the overall percentage of insurance accepted has declined among private insurance and Medicare, but no change was found in Medicaid acceptance rates.² Research shows that the uninsured experience an unmet need that is five times greater than the insured population.²⁹ With an increasing number of insured resulting from the Patient Protection and Affordable Care Act (ACA) and a focus on mental health coverage parity, the demand for providers has increased.²⁴

Provider shortages

According to Kaiser Family Foundation (2018), approximately 32.52% of the need for mental health services has been met in the United States.³⁷ By state, the greatest needs are found in the District of Columbia and Delaware with only 5.31% and 7.77% of mental health needs met, respectively.³⁷ On the contrary, Hawaii and New Jersey have met the greatest percentage of their population's mental health needs, 75.23% and 71.51%, respectively.³⁷ One study found that psychiatrists located in the Midwest were more likely to accept private health insurance than psychiatrists located in the Northeast, South, and West. However, no regional differences in insurance acceptance rates were found among Medicare and Medicaid.²

Costs

In 2009, the estimated total cost of BPD (types I and II combined) was \$160 billion.⁷ The costs associated with treating BPD can not only affect people physically, but it can also affect people financially. Guo et al. (2008) indicate that treatment costs for patients with BPD can range from \$7200 to \$12,100 annually.¹¹ There are different levels of care that are associated with these costs. About 31% of these costs are associated with inpatient care, 24% for prescriptions, and 16% for outpatient visits and physician visits.¹¹ There are also costs that can be associated with the presence of comorbidities. In analyzing total treatment costs of BPD, 67% of costs

are associated with treating the comorbidities.¹¹ Ischemic heart disease, personality disorders, and substance abuse were the comorbidities that had the highest costs due to an increased risk of hospitalization and ER visits (Guo, 2008). Policies need to be implemented that focus on cost control for patients with BPD. Without them, patients refuse psychiatric care due to this financial burden.

Solutions

Programs

To enhance timeliness of mental health diagnoses, treatment planning, and quality of care, the National Institute of Mental Health stresses the importance of collaborative care, including Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). With a collaborative care model, the patient's primary care doctor, behavioral health care manager, and patient collaborate on the development of a treatment plan.^{22,28} The behavioral health care manager communicates frequently with the patient to sure the patient is following the plan, determine the quality and successfulness of the plan, and suggests modifications as needed.²² The premise behind these collaborative care models is rooted in the Institute for Healthcare Improvement's triple aim of improving the patient's experience, improving the population's health, and reducing the cost of healthcare.¹⁵ One critical component of collaborative care models, especially with the inclusion of mental health care, is the use of the Chronic Care Model (CCM).²³ The CCM was created to help practitioners focus on providing optimal care to patients with chronic conditions by promoting use of clinical information systems, provider decision support guidelines, community resources, coordination of care, and performance improvement.²³ The CCM can effectively integrate mental health into primary care through early detection and access to appropriate treatments.²³ Through the use of collaborative care models, there can be stronger monitoring, accurate identification, and early treatment of mental illness and comorbidities. This is becoming more relevant due to the changing landscape of healthcare delivery with patients being diagnosed with mental health care conditions by their primary care physician. While a valuable source of care for patients with mental health conditions and/or those facing other barriers to accessing mental health services, primary care is not the ideal setting in which to diagnosis mental health conditions. The main reasons for this are the lack of specific mental and behavioral health training and a tendency to prescribe medications instead of using alternative treatment options. The American Psychiatric Society has found that collaborative care can do a variety of things for a facility; it can lower costs, improve quality and access, while also improving patient outcomes. With the incorporation of collaborative care there can be a shift toward more appropriate levels of care. The National Institute of Mental Health recommends primary care offices add behavior healthcare managers to enhance proper evaluation of the mental health of patients.³⁸ By changing the model of delivery, increased options of care beyond medication can be realized, which will help increase the quality of care provided to patients

with mental illnesses, such as BPD.¹⁸ found that a bipolar CCM (B-CCM) was effective for patients with and without additional psychiatric or substance abuse comorbidities. This success may be related to the structure of B-CCMs that focus on more acute manic and depressive episodes by integrating holistic care for the patient, evidence-based pharmacotherapy, and integrated service delivery.¹⁸

Policies

Policies within mental health are currently not easy to find because the topic is often overlooked and controversial in politics. One instrumental policy was the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.⁵ This federal law mandated group health insurance plans and issuers that offer mental health and substance abuse coverage offer equally favorable benefits as offered for medical/surgical health conditions.⁵ This policy is a first step toward the acknowledgment of mental health conditions as major health concerns and the elevation of mental health to be considered on par with physical health.

Another fundamental mental health policy that was recently passed was HR Bill 2646 and Senate Bill 2680, known as Helping Families in Mental Health Crisis Act. This Act was passed by Representative Tim Murphy (R-PA) in 2016 after a mass shooting in Orlando, Florida. This bill will benefit the U.S. mental health system by increasing the number of beds within mental health facilities, which will allow more patients to receive needed care. The funding for mental health facilities annually will be increased to \$20 million from \$15 million. This also provides many alternatives to incarceration in an effort to limit the number of individuals with serious mental illness who are incarcerated for nonviolent offenses. Block grants that are also issued from the states will be increased by 2%, so that there can be increased funding that is actually reaching and benefiting patients with BPD. There are also sections that address discrimination among different health care providers. These are entities such as hospitals, Medicare and Medicaid. This is to ensure that the best care is being provided to patients regardless of history, while being able to be treated stigma free. Democrats held strong support for this bill because it gave light to an important topic, although they felt that Republicans missed a key issue being gun control.¹²

As discussed in the previous section, collaborative care models are receiving support from key stakeholders in the industry, one being Medicare. In January 2017, the Centers for Medicare & Medicaid Services (CMS) began a separate payment model for primary care clinicians who treat patients using the collaborative care model.²² The purpose behind this new payment model is to financially incentivize primary care providers to offer collaborative care services. The other goal is that by initiating this new payment model, it may encourage private insurance companies to follow with comparable reimbursement structures.²²

How can policies help? When thinking of treatment costs, policies can start monitoring the comorbidities of BPD. By conducting more screening and taking key preventative measures providers can slow down the acceleration of symptoms and allow for quicker channels of treatment for high risk comorbidities. A policy that should be considered for

collaborative care would be proposing plans that follow the outlines used by Medicare and Medicaid. Medicare and Medicaid have three main players within the collaborative care model that are used. The first being the treating practitioner, who usually specializes in primary care. There is also a behavioral health care manager that is used, this is someone who has specialized education within behavioral healthcare. Psychiatric consultants are also used within primary care facilities, this is also a trained mental health professional that can prescribe prescriptions for patients. There are assessments done by the primary care doctor and the psychiatric consultant. These professionals coordinate a plan with the behavioral health care manager to find the best route of treatment. Allowing for the patient to get the most from their care. By allowing for collaborative care to be covered this can ultimately kill two birds with one stone. Those with less severe forms of BPD and mental health illnesses will be able to receive a more appropriate level of care. This will also allow for closer monitoring of key comorbidities found within mental health patients. Covering collaborative care can help save for the patient and the insurance company large sums of money.²²

Conclusions

Patients with BPD often suffer from one or more comorbid conditions, which makes treatment more complex and costly. With stigma, access to care barriers, and increasing cost of healthcare, focus should shift to policy development to reduce stigmatization, further enhance insurance coverage, and increase accessibility of mental health providers. Furthermore, newer models of care delivery, including patient-centered medical homes and Accountable Care Organizations, will need to integrate mental and behavioral healthcare into physical health not only for BPD but for all mental health conditions.

Compliance with ethical standards

The authors have no conflicts of interest to disclose. This research did not involve human and/or animal participants; therefore, no informed consent was needed. This project was approved by the university's institutional review board.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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