

Research Article

# Psychiatry: The Relevance of Improving Access to Healthcare for Acutely Mentally Ill and Those with Longstanding Mental Illness

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## Abstract

**Background:** There is currently a national mental health crisis due to the lack of access to mental health care. **Objectives:** 1. To study the different factors that contribute to lack of access to psychiatric treatment. 2. To compare each factor by ranking them according to their relevance in contributing to the lack of access to health care and national mental health crisis as perceived by psychiatrist respondents to a brief survey. 3. To analyze results, discuss implications, and provide recommendations. **Methods:** Seven factors contributing to lack of access to psychiatric treatment are identified from a review of literature, educational materials, and clinical practice. A cross-sectional survey of psychiatrists in US practice is conducted from July to December 2023 by convenient sampling. Recruitment is done in person and via email, US postal mail, and telephone. Forty-eight respondents rated these factors in a Likert scale and ranked them, taking 15 minutes to complete each survey. Quantitative data are analyzed descriptively, and qualitative data are analyzed deductively by identifying the themes from respondents' narratives. **Results:** The factors contributing to lack of access to psychiatric treatment are ranked as follows: 1. Lack of support to mental health organizations to establish and operate high-performance mental healthcare delivery (score: 11). 2. Leadership problem and administration problem (score: 12). 3. Stigma in psychiatrists and patients (score: 10) 4. Lack of support in training medical students (score: 9) 5. Disparity in mental healthcare delivery (score: 6) 6. Breakdown of family structure as, "Family is the cradle of good citizenship" (score: 8) 7. Shortage of psychiatrists (score: 6). The theme that emerged from respondents' narratives about keeping their job are: 1. Enjoyment 2. Financial 3. Altruism 4. Structure. **Conclusions:** This study has affirmed the relevance of Psychiatry and the need to improve access to mental healthcare. This will require systemic approach from mental health providers to communities, institutions, and healthcare organizations. It is hoped that studies such as this will spark a cultural transformation that will reverse healthcare access issues.

## Keywords

Mental Health Crisis, Survey, Accessibility Factors, Psychiatrist Respondents

## 1. Introduction

"Without mental health, there is no true physical health" [1]. Currently, there is a national mental health crisis due to a lack of access to mental healthcare. This accessibility issue to mental healthcare has a significant impact on the most vul-

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nerable minority populations; immigrants [2]; racially/ethnically diverse Black, Indigenous, People of Color (BIPOC); women in maternity and perinatal phase [3]; older adults [4]; and those who are gender diverse or identify as LGBTQIA+. This vulnerable population includes those who are marginalized [2]; those who are incarcerated [7]; and those with complex and chronic debilitating medical conditions [4, 8]. For example in migrants, mental distress is greatest in the marginal category and rejection category, and least in the integration category. Intermediate mental distress is found in assimilation and separation categories [2]. Please refer to Tables 4 and 5. The chronicity and burden of comorbid mental health disorders within these vulnerable populations directly impact the patients and indirectly impact their families and society in multiple ways. Without prompt and appropriate psychiatric treatment, it leads to their early demise due to suicide, homicide, accidents, unintentional injuries, downward drift phenomenon, treatment-resistant psychiatric, and comorbid medical conditions. The burden and chronicity of unmanaged psychiatric conditions in patients is a challenge for families to remain intact and function in harmony. Due to the patients' lack of productivity, it leads to a reduced workforce and bleak societal economics [9, 41]. As can be seen in Figure 7 of Appendix IV, the costs of untreated mental illness in the US are estimated to be between \$300 billion and \$500 billion per year.

According to National Alliance on Mental Illness statistics, individuals in the Veterans Health Administration have a prevalence of 40% of diagnosed mental illness or substance use disorder. The prevalence of major depressive disorder is 9.7%, anxiety disorders 20% bipolar I disorder 2.8%, and schizophrenia, 1.19%. Patients diagnosed with schizophrenia are estimated to have an annual fiscal burden in the US of \$173.6 billion and the lifetime fiscal loss to the government per person is \$1,540,042. According to the Centers for Disease Control and Prevention, suicide is a leading cause of death in the U.S. with 45,979 deaths in the U.S. [5]. Native Americans and their communities are disproportionately impacted by suicide [5, 6]. In the years between 2019 and 2020, suicide rates increased by 6% among Native Americans and by 4% among Blacks. There was a 4% decrease in suicide rates among the Whites. The prevalence of suicidality is 17.2% among high school students, and 47.7% of LGBTQ youth express suicidality [10]. Adverse childhood experiences (ACE) are associated with earlier instances of substance use [11]. The youth have difficulty achieving their educational goals and suffer from identity crisis. Healthcare policies are formulated in an attempt to reduce distress and suffering, but some are controversial and cause opposition and division in the community (i.e., euthanasia [12], abortion, in-vitro fertilization, rationing of healthcare benefits for the elderly, and disparity [13-16] in healthcare).

For the most part, we, as psychiatrists, have our focus solely on the patients, but just as with the dyadic relationship mother-infant dynamics of psychopathology, child psychia-

trists look at the wellbeing and strength of the mother to accomplish her task to influence the health of her infant. In this analogy, I shift the focus on the psychiatrist-patient dyadic relationship wherein mental health providers and intricate mental healthcare systems influence patient treatment outcomes and the current state of national mental health.

Lack of access to mental healthcare has been in existence chronically, but it is further aggravated by the COVID-19 pandemic, an acute-on-chronic problem that is considered "syndemic" [17] due to simultaneous emergence of multiple epidemic problems. The US mental healthcare issue is also manifested worldwide as mental health gap [18]. Psychiatric treatment spans from the realm of prevention, treatment of the mental disorder, and finally to recovery [13, 14] at all human life ages.

Focusing on who are the key players in healthcare, please refer to the standard stakeholder grid chart [44] in Figure 1. Looking at the top-right quadrant, both patients and psychiatrists need to be managed closely because these stakeholders have high levels of both power/influence and interest. They need ongoing focus and communication.

At the top-left quadrant, healthcare organizations, healthcare leaders, and courts have high power and influence, but their level of interest is lower. These stakeholders need to be kept satisfied over time, and in some cases, helped to develop stronger interest so that they can be additional advocates of improvements in mental-health access.

The stakeholders at the bottom-right quadrant (patients' families, psychiatrist providers' network, and insurance plan) have a high level of interest, but much lower power and influence. They simply need to be kept informed.

The stakeholders at the bottom-left quadrant (housing agency, school, faith institution, drug company, bio-technology, innovation, and police department) have low levels of power/influence and interest related to the issue of mental-health access, so they simply need to be monitored to see if their positions in the grid change.

Finally, plausible scenarios that each stakeholder can shift to a different grid should be envisioned, especially with the change of healthcare landscape. For example, insurance plan which needs to be kept informed can acquire so much power and influence that would rightly fall at the top-right quadrant to be managed closely.

## 2. Objectives

The objectives of this study are:

1. To study the different factors that contribute to lack of access to psychiatric healthcare and the national mental health crisis.
2. To compare the factors by ranking them according to their relevance as perceived by psychiatrists who responded to a brief survey.
3. To analyze results, discuss implications, and provide recommendations.

It is hoped that this study can contribute to the solution of the above problems by offering clear perspectives on the topic of mental healthcare. The goal is that this overarching perspective will provide a segue way for further research, ideas, and policies to improve patients' well-being and to educate the public.

### 3. Methods

A cross-sectional, seven-item factors, questionnaire survey was offered to psychiatrists from July 2023 to December 2023. Psychiatrists' names were obtained via convenience sampling through in-person, email, US postal mail, and telephone. A mixed-method study approach incorporating both qualitative and quantitative aspects was utilized. The setting of the research project includes US psychiatric practices (particularly residency and fellowship institutions), listservs of psychiatric organizations, psychiatric conferences, state board medicines websites, and other mental-health entities. For ease of conceptualization, the tabulation of the results and figures is found in Appendix I.

The seven factors are identified and derived from a review of literature, educational materials, and clinical practice. The factors are identified and rated on a grid scale and are ranked by the respondents. The survey requested that respondents utilize a Likert-scale rating for each factor: (5) completely agree, (4) partially agree, (3) neutral, (2) partially disagree, and (1) completely disagree. The seven factors are:

1. Lack of support to mental health organizations to establish and operate high- performance mental healthcare delivery.
2. Leadership problems or administration problems in mental health organizations.
3. Shortage of psychiatrists [28].
4. Stigma in psychiatry and patients with mental illness [21, 35].
5. Lack of support in training medical students [34].
6. Breakdown of family structures [26, 27]: Family is the, "Cradle of good citizenship." [29].
7. Disparity in mental healthcare delivery [13-16, 23, 32, 33].

An open-ended, qualitative portion of the survey allowed the respondents to reflect on the factors that caused them to remain in their psychiatric practices and career field. The data were analyzed according to frequency and percentages. The questionnaire used is found in Figure 4 and Figure 5 of Appendix II. A poster for this research is illustrated in Figure 6 of Appendix III.

### 4. Results

Considering that this was a mixed-method study, the first part will describe quantitative results and the second part will discuss the qualitative results. There were 50 survey responses, but two were duplicated by the same psychiatrists, reducing the analytic sample to 48 responses. The demo-

graphic characteristics of the respondents were also considered but de-identified and reported in aggregate as percentages in Table 1 of Appendix I. Many of the respondents fall into the 65-69 age bracket (19%), followed by the 55-57 age bracket (17%). The oldest respondent is 85 years of age, and the youngest respondent is 34 years of age. Most of the respondents have between 25-29 years of psychiatric service (20%). The survey respondents were evenly distributed between males and female.

For factor (1) "Lack of support to mental health organizations," the largest group of respondents partially agreed (44%), followed by those who completely agreed (29%). For factor (2) "Leadership problem or administration problem," the results were distributed differently, with the largest group of respondents selecting partially agree (35%), followed by those who chose neutral (21%). For factor (3) "Shortage of psychiatrists," the largest group of respondents chose completely agree (35%), followed by those who partially agree (22%). For factor (4) "Stigma in psychiatry and patients with mental illness," the majority of the respondents partially agree (52%), followed by those who chose completely agree (23%). For factor (5) "Lack of support in training medical students, psychiatry residents, and psychiatry fellows," the largest group of respondents partially agreed (46%) followed by those who chose neutral (21%). For factor (6) "Breakdown of family structure as, 'Family is the cradle of good citizenship,'" the largest group of respondents partially agreed (23%), followed by those who chose neutral (21%). For factor (7) "Disparity in mental health," the majority of the respondents completely agreed 56%, followed by those who partially agreed 27%. These results can be seen in Table 2 of Appendix I.

The respondents ranked the seven factors according to their perceived relevance in contributing to the national mental-health crisis. Initial findings reveal a tie between four factors, all of which scored 11. These include factors (1) Lack of support to mental health organizations, (3) Shortage of psychiatrists, (6) Breakdown of family structure as, "Family is the cradle of good citizenship," and (7) Disparity in mental healthcare delivery. A tiebreaker was needed to distinguish between factors (1) and (2), as both have the same score of 12 in the second rank. Factor (1) was given the highest level in rank #1 because it has the highest scores in rank #1 and rank #2. Factor (2) earned the rank# 2. The rankings can be seen in Table 3 of Appendix I. The final ranking of the seven factors is as follows, with rank #1 as the most relevant factor contributing to the national mental health crisis to rank #7 as the least relevant factor. Please see Figure 3 of Appendix I.

1. Rank #1. Item factor 1, Lack of support to mental health organizations
2. Rank #2. Item factor 2, Leadership problem or administration problem
3. Rank #3. Item factor 4, Stigma in psychiatrists and patients
4. Rank #4. Item factor 5, Lack of support in training

medical students, residents, and fellows

5. Rank #5. Item factor 7, Disparity in mental healthcare
6. Rank #6. Item factor 6, Breakdown of family structure as, "Family is the cradle of good citizenship."
7. Rank #7. Item factor 3, Shortage of psychiatrists

One open-ended question asked, "What is your primary motivation to keep your psychiatry job?" The respondents' narrative statements were noted, and from these, four themes were identified. These include 1. Enjoyment 2. Financial 3. Altruism 4. Structure. These are illustrated in Figure 2 of Appendix I. Responses to another open-ended question requesting comments/insights/opinions are incorporated in the discussion.

## 5. Discussions

In the literature review, no studies were found comparing the seven factors contributing to the national mental health crisis from lack of access to mental healthcare through the lens of psychiatrist respondents. It is noted the most prevalent group of respondents was the 65-69 age bracket (19%), followed by the 55-90 age bracket (17%). Thus, the majority of respondents are in the Baby Boomer generation. The years of practice in psychiatric service was revealed to be 25 to 29 years of service among the respondents. Their primary motivation to keep their psychiatric job is illustrated in Figure 2 and four themes were identified as enjoyment, financial, altruism, and structure.

The number-one ranked factor is the lack of support to mental health organizations. This may be partly due to the high cost of mental healthcare, especially maintaining acute inpatient units, hospitals, or behavioral centers which require several highly specialized professional employees to perform as a team aimed at delivering high-performance psychiatric treatment. In addition, an integrated multimodal approach is essential in running an acute inpatient psychiatric facility, requiring adequate staffing of psychiatric nurses, psychotherapists, occupational therapists, art therapists, music therapists, psychiatric technicians, case managers, internal medicine doctors, pediatricians, and teams of psychiatrists. With changes in the healthcare landscape through acquisitions and mergers, there is a shift from hospital inpatient treatment to lower levels of care such as day hospital programs, intensive outpatient programs, and outpatient clinic settings. The treatment barrier to acute psychiatric hospitals has become very high, while at the same time, there is a long waiting list in most outpatient clinics to accept new intakes. A psychiatrist respondent gave her comment/insight/opinion as follows:

"I believe, in part, the mental health crisis is due to a breakdown of American health system. Insurance companies do not reimburse or pay for psychiatrists to have meaningful and thoughtful visits with their patients. Instead, insurance reimburses for quantity not quality. Psychiatrist and patient burnout become compounded, and we are not the only doctors/people who feel this way."

Psychiatrists do realize acute psychiatric hospitalization is still much needed, especially in the first psychotic break in youths [31] who need prompt and timely initiation of psychiatric treatment to achieve immediate recovery and prevent chronic sequelae. Emergency situations such as suicide attempts, dangerousness to others, or inability to care for oneself need the therapeutic milieu of hospital psychiatry. Mental health entities or organizations must find the unmet needs of their patients or clients, first-line health care providers, and their administration leaders. With the right spirit, empathy, active listening, observing, and laboring enough to obtain and integrate information from the bottom-up, the goal is to provide support to mental healthcare services that are very much aligned with the needs of the users of the services [22, 25].

The Quadruple Aim [36], which is the guiding light for many healthcare organizations to achieve high-performance mental healthcare delivery, would improve the work-life balance of psychiatrists and mental healthcare providers, improve patient experience, improve population health, and reduce healthcare costs.

The factor whose relevance ranked second is leadership and administration problems. The administration has to employ leaders in their healthcare organizations who are endowed with good intrapersonal characteristics and with knowledge, skills, and abilities [19, 20]. Interpersonal characteristics are essential, especially having refined qualities of confident humility, moral authority, psychological safety, and watchful vigilance for internal scanning and external scanning of risks, threats, and opportunities. Leaders must assume the role of "change champions" to create positive cultural change in their organizations. Good healthcare leaders are familiar with finance and accounting, economics, health law, utilization and management, healthcare marketing, effective communication, and partnerships. They support networking that is open, diverse, and deep in promoting integration and solidarity in the health organization. Employers must be mindful of Employee First/Customer Second (EFCS) [20].

The third relevant factor is the stigma in Psychiatry as a medical field amongst other medical specialties [21]. In a broader sense, the patients themselves are also stigmatized [35] intrapersonally, interpersonally, and socially. The portrayal of mental illness in movies has its pros and cons. It can increase cultural sensitivity, raise awareness, or worsen stigma and instill fear. Many psychiatric units are situated in very remote areas of general hospitals and are the least prioritized for structural improvements. The patients feel the stigma, and their families feel the stigma as well. One psychiatrist respondent remarked:

"There is continued stigma in Psychiatry, and the patients feel these in receiving care due to their mental health diagnosis. Hopefully, there is normalizing of the disparity in mental health delivery. More support is necessary for mental health and substance use disorders."

The fourth-ranked factor is lack of support in training medical students, residents, and fellows. It used to be that



medical students had the notion that they should not reveal their mental health needs as this was equated to weakness by their superiors. In addition, licensing boards require physicians to have no prior history of mental illness. Medical students also have inadequate health insurance coverage [34] for mental health care. Some do not have the option to seek psychiatric providers outside of their educational institution and so confidentiality and treatment efficacy are sacrificed. Psychiatric trainees from the global majority must be encouraged and supported to promote inclusion, equity and diversity and promote resiliency within their patient population.

The fifth-ranked factor is disparity in psychiatric healthcare delivery. Discrimination toward the Black, Indigenous, and People of Color (BIPOC) populations compared with the White Population has contributed to racial and ethnic disparities in healthcare. Overdiagnosis or diagnostic bias of Black people for non-affective psychosis appears to have limited measured data in the U.S. [2]. Patients who have persistent symptoms and frequent hospital admissions experienced feeling mistreated and unwelcomed by hospital staff. These patients are usually characterized by social determinants of health [14] that include poor education, poverty, food insecurity, lack of social support, poor living conditions, and poor infrastructures-all of which are drivers of health disparities that pose risk factors for mental health illness. The only recourse for these patients is to seek support in acute psychiatric inpatient facilities, which often results in frequent hospital admissions. There is a great need to implement practices that promote diversity, equity [39], and inclusion [23] in mental healthcare to mitigate behavioral and cognitive biases and improve healthcare access.

The sixth-ranked factor is the breakdown of family structure. This is second to the least relevant factor, likely because it is beyond the control of the treating psychiatrist's utilization of their treatment armamentarium. The single-parent household has increased, and the two-parent household has become "household privilege." Fragmented families exist across all socioeconomic strata. It is a sensitive topic to discuss, but certainly, personality development occurs first within the institution of family as the first teaching social container where love, nurturance, and protection are safeguarded [24, 26, 27]. The mother in the mother-infant dyad dynamic needs to be supported, strengthened, and protected to help her accomplish her task to influence and safeguard the health and wellbeing of her infant. There is a need to improve maternal health in preconception, during the pregnancy period, and during the postpartum period by placing emphasis on the fact that early childhood wellbeing is a critical period of human development [24, 38]. Improving developmental outcomes of children is the goal, and if this is curtailed right at the very beginning of human development, it follows there is less human capital, low economic productivity, vicious intergenerational cycles of poverty, and poor population health and well-being. In other words, ensuring improved developmen-

tal outcomes for children will support the propagation of the human species. The presence of fathers [26, 30] in the family structure is important; they need to be greatly supported, especially when they are faced with challenges such as the phenomenon of "male drift" [26]. Family has the primary goal to provide support, protection, monitoring, encouragement, growth with a well-balanced connection and autonomy. Extensive social pressures and challenges can exhaust the strengths of families with extreme pathological reactions of enmeshment, rigidity, coercion, punishment, detachment, and isolation [43]. One psychiatrist respondent on the comments/insights/opinions on families, stated, "It may be different for different populations."

Another psychiatrist respondent opined:

"Disintegration of the family unit is detrimental to a person's mental health. The family of origin is the basic foundation of a child's biopsychosocial development."

The shortage of psychiatrists was ranked last, seventh, by the respondents. Despite the common notion that there is fast turnover of US physicians due to burnout [37, 40, 42], it appears that from this sample, the majority of the psychiatrists are baby boomers, and they are still actively involved in their profession. One can tell from their narratives in the qualitative data that they have strong reasons to remain involved. There have been gaps in "passing the baton" to early career psychiatrists. Good leadership and mentorship form true collegial relationships for the mentor-mentee with good modelling. Leadership and mentorship provide the opportunity to dispel gaps, behavioral biases, and cognitive biases and to promote the practice of psychiatry.

## 6. Limitations

This study is cross-sectional, self-funded, and time limited for 6 months. It has a small sample size, recruited by convenient sampling with potential bias. It is a descriptive study conducted by an individual-solo MHL student of Brown University.

## 7. Recommendations

As a recommendation for future scientific research, a grant-funded follow-up study on a much larger sample size would be in order. It should feature a longitudinal research design, random sampling devoid of bias, and adequate utilization of qualitative and quantitative techniques of data gathering and interpretation. Such a study would bring forth reliable information and educational advancement to psychiatry and promote national mental health wellbeing. With better and more compelling information, policy makers will be in a position to formulate socially just and inclusive policies geared to solving the mental health crisis.

Support is needed:

1. To help mental health organizations reclaim their sta-

bility, to encourage the startup of small mental health entities, and to develop a true partnership between the public and private sectors.

2. To support healthcare leaders and those in administration by granting them good, updated educations, better metrics, and better systems. The goal should be to keep them abreast, engaged, and motivated, especially because they have the futures of their patients in their hands.
3. To raise awareness of the need to reduce patient stigma, and to enhance patients' experience of belonging, appreciation, and acceptance.
4. To help educational institutions in the training of medical students, residents, fellows, mentors, and mentees, especially medical students coming from minority groups.
5. To eliminate disparities in mental healthcare.
6. To provide every family with good and affordable health insurance coverage for children, resources for single-parent households, adequate rehabilitation for incarcerated fathers (including eventual reunification with their families), and adequate protection to mothers, especially single mothers.
7. To enable past, present, and future psychiatrists to provide quality mental healthcare to their patients.

## 8. Conclusions

The findings from the questionnaire survey, my extensive

research, and my education and professional career have affirmed for me the relevance of Psychiatry and the need to improve access to mental healthcare to mitigate the widespread impact of our national mental health crisis. Achieving this need will require a cohesive, systemic approach from mental health providers to communities, institutions, and healthcare organizations. It is hoped that studies such as this, done across much larger samples, will provide the data and arguments needed to spark a cultural transformation that will reverse today's access issues.

## Abbreviations

BIPOC	Black, Indigenous, and People of Color
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, + (Other Sexual Identities)
ACE	Adverse Childhood Experiences

## Author Contributions

Mercedes Agudo is the sole author. The author read and approved the final manuscript.

## Conflicts of Interest

The author declares no conflicts of interest.

## Appendix

### Appendix I: Tables and Figures

**Table 1.** Demographic Characteristics Demographic characteristics of psychiatrists who responded to the survey.

CHARACTERISTICS	FREQUENCY (n = 48)	PERCENTAGES (%)
GENDER		
Male	24	50%
Female	24	50%
EXTENT OF TIME SPENT AT WORK		
Full time	36	75%
Part time	8	17%
Retired	4	8%
AGE BRACKET IN YEARS		
30-34	1	2%
35-39	2	4%
40-44	2	4%

CHARACTERISTICS	FREQUENCY (n = 48)	PERCENTAGES (%)
45-49	5	10%
50-54	6	13%
55-59	8	17%
60-64	3	6%
65-69	9	19%
70-74	5	10%
75-79	5	10%
80-84	1	2%
85-89	1	2%
YEARS OF PRACTICE AS PSYCHIATRIST		
0to4	4	8%
5 to 9	4	8%
10 to 14	5	10%
15 to 19	2	4%
20 to 24	4	8%
25 to 29	9	20%
30 to 34	5	10%
35 to 39	2	4%
40 to 44	7	15%
45 to 49	4	8%
50 to 54	1	2%
55 to 59	1	2%

**Table 2.** Factor Responses. Psychiatrists' responses to a brief survey pertaining to the above 7 factors rated in a 5-grid scale.

Factor	1 Completely Disagree	2 Partially Disagree	3 Neutral	4 Partially Agree	5 Completely Agree
1. Lack of support to mental health organizations	4 (8%)	1 (2%)	9 (19%)	21 (44%)	14 (29%)
2. Leadership problem or administration problem	3 (6%)	4 (8%)	10 (21%)	17 (35%)	14 (29%)
3. Shortage of psychiatrists	0 (0%)	1 (2%)	8 (17%)	22 (46%)	17 (35%)
4. Stigma in psychiatry and patients with mental illness	1 (2%)	2 (3%)	9 (19%)	25 (52%)	11 (23%)
5. Lack of support in training medical students, psychiatry residents and psychiatry fellows.	3 (6%)	6 (13%)	10 (21%)	22 (46%)	7 (15%)
6. Breakdown of family structure as, "Family is the cradle of good citizenship."	3 (6%)	12 (25%)	10 (21%)	11 (23%)	12 (25%)

Factor	1 Completely Disagree	2 Partially Disagree	3 Neutral	4 Partially Agree	5 Completely Agree
7. Disparity in mental health care delivery	1 (2%)	3 (6%)	4 (8%)	13 (27%)	27 (56%)

**Table 3.** Factor Rankings Ranking of the 7 items by psychiatrists with number 1 as the most relevant factor to national mental health crisis and number 7 as the least relevant factor to national mental health crisis.

Factor	NUMBER of RANKINGS (Respondents asked to rank the factors by importance)						
	#1	#2	#3	#4	#5	#6	#7
1. Lack of support to mental health organizations	11	12	8	9	0	5	1
2. Leadership problem or administration problem	4	12	6	6	6	4	8
3. Shortage of psychiatrists	11	8	8	8	5	2	6
4. Stigma in psychiatry and patients with mental illness	4	11	10	8	5	7	1
5. Lack of support in training medical student, psychiatry residents and psychiatry fellows.	1	7	8	9	9	7	6
6. Breakdown of family structure as, "Family is the cradle of good citizenship."	11	6	7	4	5	8	15
7. Disparity in mental health care delivery	11	7	6	6	6	4	4

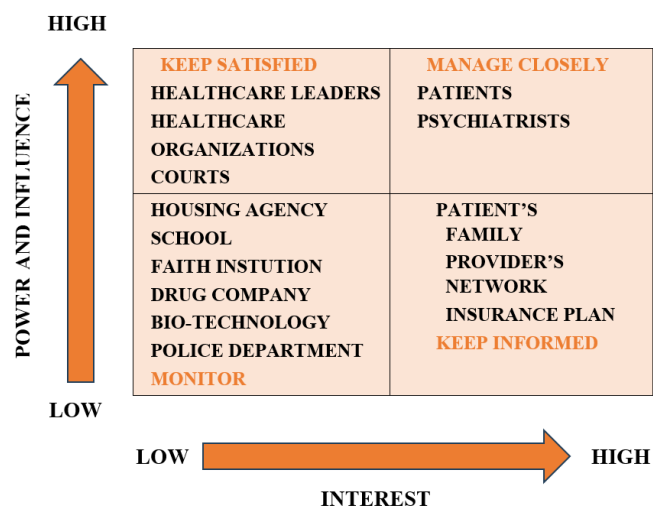
**Table 4.** Questions addressed to immigrants [45].

Addressed to immigrants	Is the new culture valued and to be adopted?	
	YES	NO
Is the old culture valued and to be retained?	YES	INTEGRATION
	NO	ASSIMILATION
		SEPARATISM
		MARGINALITY

**Table 5.** Questions addressed to host communities [45].

Addressed to Host Communities	Are newcomers helped and encouraged to adopt the host culture and rewarded for doing so?	
	YES	NO
Are racial differences and alternative lifestyles respected?	YES	INTEGRATION
	NO	ASSIMILATION
		SEPARATION
		MARGINALITY





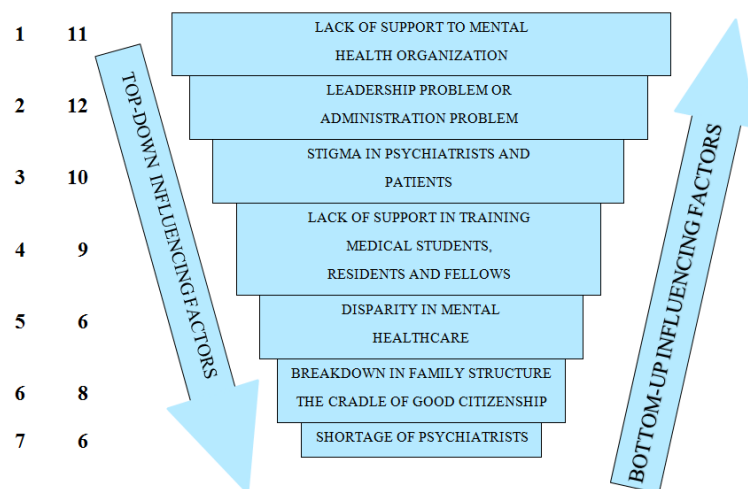
*Figure 1. Stakeholders Grid Chart [44].*



*Figure 2. Qualitative Data.*

What is your motivation to keep your primary job?

RANK SCORE



*Figure 3. Ranking of Factors.*

Ranking of the seven item factors with the base as the least relevant to the top as the most relevant factor related to national mental health crisis.

## Appendix II: Questionnaire/Survey

### DEMOGRAPHIC INFORMATION OF RESPONDERS (Psychiatrists)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Occupational Role: \_\_\_\_\_

Number of years working in your occupational role: \_\_\_\_\_

Are you:

Actively working full time? Y/N

Actively working part time? Y/N

Retired? Y/N

How many occupation types did you have before your current occupational role?

Enumerate them below:

If you are currently INACTIVE, RETIRED, or ON LEAVE:

Are you actively planning to return to Psychiatric workforce?

What is your prime motivation of wanting to return back?

If you are actively working right now, what is your primary motivation to keep your occupation?

Thank you!

*Figure 4. Demographic information of Psychiatrist respondents.*

## QUESTIONNAIRE SURVEY

1. National mental health crisis is partly due to lack of support to mental health organizations to establish and operate high performance mental health care delivery.  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree
2. National mental health crisis is partly due to leadership problem or administration problem.  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree
3. National mental health crisis is partly due to shortage of Psychiatrists.  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree
4. National mental health crisis is partly due to stigma in Psychiatry and patients with mental illness  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree
5. National mental health crisis is partly due to lack of support of training medical students, psychiatry residency programs, and psychiatry fellowship programs.  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree
6. National mental health crisis is partially due breakdown of family structure as, "Family is the CRADLE of good citizenship."  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree
7. National mental health care crisis is partly due to disparity of mental health care delivery.  
1                      2                      3                      4                      5  
Completely disagree    Partially disagree    Neutral    partially agree    Completely agree

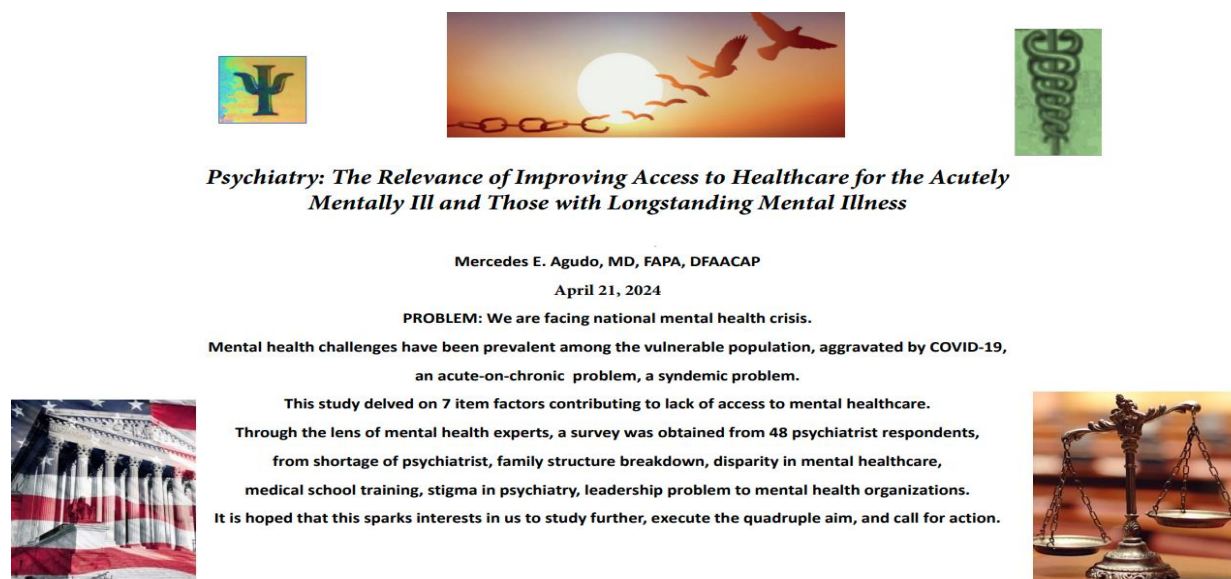
Related to national mental health crisis due to lack of access to mental healthcare, rank the following with 1 being the highest relevant factor and 7 being the least relevant factor.

Ranking	Factors
	Lack of support to mental health organizations to establish and operate high performance <u>mental health care delivery</u> .
	Leadership problem or administration problem of health care organizations
	Shortage of Psychiatrists.
	Stigma in Psychiatry and patients with mental illness
	Lack of support for training of medical students, psychiatry residency programs, psychiatry fellowship programs.
	Breakdown of family structure as "Family Is the CRADLE of good citizenship."
	Disparity of mental health care delivery

## COMMENTS/ INSIGHTS/ OPINIONS:

**Figure 5.** Questionnaire survey in Likert scale and ranking of the seven item factors contributing to accessibility issue of mental healthcare.

## Appendix III: Research Poster



**Figure 6.** Research Poster to visualize a brief overview of the research.

## Appendix IV: The Annual Cost of Untreated Mental Illness



<sup>1</sup> "E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way", last modified December 25, 2013, <http://www.nytimes.com/>.

<sup>2</sup> "Guilty of mental illness", last modified April 27, 2015, <http://chicagoreporter.com/>.

<sup>3</sup> "A shocking number of mentally ill Americans end up in prison instead of treatment", last modified April 30, 2015, <https://www.washingtonpost.com/>.

<sup>4</sup> Steven Melek and Doug Norris, Chronic Conditions and Comorbid Psychological Disorders, 2008.

<sup>5</sup> "Mental Disorders Cost Society Billions in Unearned Income", last modified May 7, 2008, <https://www.nimh.nih.gov/>.

**Figure 7.** The annual cost of untreated mental illness. Source: Valant Medical Solutions. *The Cost of Untreated Mental Illness*. 2017 Jan 26 [46].



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